	STATE OF ARIZONA **Department of Health Services** NOTICE OF REQUEST FOR PROPOSALS	**ARIZONA DEPARTMENT OF HEALTH SERVICES** 1740 West Adams Street Phoenix, Arizona 85007 (602) 542-1040 (602) 542-1741 Fax

SOLICITATION NUMBER: **SOLICITATION NUMBER: HP832090**

SOLICITATION DUE DATE/TIME: **May 19, 2008 3:00 pm- Local Time**

SUBMITTAL LOCATION: **Arizona Department of Health Services, Office of Procurement, 1740 West Adams Street, Room 303, Phoenix, Arizona 85007**

DESCRIPTION: **Children's Rehabilitative Services Program**

PRE-OFFER CONFERENCE:

Date	Time	Location
April 28, 2008	**8:30 am**	**150 N. 18th Avenue Room 540A (5th Floor) Phoenix AZ 85007**

In accordance with A.R.S. § 41-2534, competitive sealed proposals for the services specified will be received by the Arizona Department of Health Services at the above specified location, until the time and date cited. Offers received by the correct time and date will be opened and the name of each Offeror will be publicly read. To obtain a copy or review the solicitation, log onto www.azdhs.gov and click on the Quick Links Procurement site. If obtaining a copy via the internet, potential Offerors should check periodically for any updates to the above solicitation. **Amendments may be issued to this solicitation at any time. It is the responsibility of the supplier/Offeror to routinely check the ADHS website for solicitation amendments.**

Offers must be in the actual possession of the Arizona Department of Health Services on or prior to the time and date, and at the location indicated above. **Late offers will not be considered**.

Offers must be submitted in a sealed envelope or package with the Solicitation number and the Offeror's name and address clearly indicated on the envelope or package. All offers must be completed in ink or typewritten. Additional instructions for preparing an offer are included in this solicitation.

With 72 hours prior notice, persons with disabilities may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility. Such requests are to be addressed to the Solicitation Contact Person named below.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

Solicitation Contact Person:

Richard Szawara

(480) 203-6866 / szawarr@azdhs.gov
Telephone Number / email

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UNIFORM INSTRUCTIONS

A. DEFINITION OF TERMS As used in these Instructions, the terms listed below are defined as follows:

1. *"Attachment"* means any item the Solicitation requires an Offeror to submit as part of the Offer.

2. *"Contract"* means the combination of the Solicitation, including the Uniform and Special Instructions to Offerors, the Uniform and Special Terms and Conditions, and the Specifications and Statement or Scope of Work; the Offer and any Best and Final Offers; and any Solicitation Amendments or Contract Amendments.

3. *"Contract Amendment"* means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.

4. *"Contractor"* means any person who has a Contract with the State.

5. *"Days"* means calendar days unless otherwise specified.

6. *"Exhibit"* means any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.

7. *"Offer"* means bid, proposal or quotation.

8. *"Offeror"* means a vendor who responds to a Solicitation.

9. *"Procurement Officer"* means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

10. "*Solicitation"* means an Invitation for Bids ("IFB"), a Request for Proposals ("RFP"), or a Request for Quotations ("RFQ").

11. *"Solicitation Amendment"* means a written document that is signed by the Procurement Officer and issued for the purpose of making changes to the Solicitation.

12. *"Subcontract"* means any Contract, express or implied, between the Contractor and another party or between a subcontractor and another

party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.

13. *"State"* means the State of Arizona and Department or Agency of the State that executes the Contract.

B. INQUIRIES

1. Duty to Examine. It is the responsibility of each Offeror to examine the entire Solicitation, seek clarification in writing (inquiries), and examine its' Offer for accuracy before submitting the Offer. Lack of care in preparing an Offer shall not be grounds for modifying or withdrawing the Offer after the Offer due date and time, nor shall it give rise to any Contract claim.

2. Solicitation Contact Person. Any inquiry related to a Solicitation, including any requests for or inquiries regarding standards referenced in the Solicitation shall be directed solely to the Solicitation contact person. The Offeror shall not contact or direct inquiries concerning this Solicitation to any other State employee unless the Solicitation specifically identifies a person other than the Solicitation contact person as a contact.

3. Submission of Inquiries. The Procurement Officer or the person identified in the Solicitation as the contact for inquiries except at the Pre-Offer Conference, require that an inquiry be submitted in writing. Any inquiry related to a Solicitation shall refer to the appropriate Solicitation number, page and paragraph. Do not place the Solicitation number on the outside of the envelope containing that inquiry, since it may then be identified as an Offer and not be opened until after the Offer due date and time. The State shall consider the relevancy of the inquiry but is not required to respond in writing.

4. Timeliness. Any inquiry or exception to the solicitation shall be submitted as soon as possible and should be submitted at least seven days before the Offer due date and time for review and determination by the State. Failure to do so may result in the inquiry not being considered for a Solicitation Amendment.

5. No Right to Rely on Verbal Responses. An offeror shall not rely on verbal responses to inquiries. A verbal reply to an inquiry does not constitute a modification of the solicitation.

6. Solicitation Amendments. The Solicitation shall only be modified by a Solicitation Amendment.

7. Pre-Offer Conference. If a pre-Offer conference has been scheduled under this Solicitation, the date, time and location shall appear on the Solicitation cover sheet or elsewhere in the Solicitation. Offerors should raise any questions about the Solicitation or the procurement at that time. An Offeror may not rely on any verbal responses to questions at the conference. Material issues raised at the conference that result in changes to the Solicitation shall be answered solely through a written Solicitation Amendment.

8. Persons With Disabilities. Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the Solicitation contact person. Requests shall be made as early as possible to allow time to arrange the accommodation.

C. OFFER PREPARATION

1. Forms: No Facsimile, Telegraphic or Electronic Mail Offers. An Offer shall be submitted either on the forms provided in this Solicitation or their substantial equivalent. Any substitute document for the forms provided in this Solicitation must be legible and contain the same information requested on the forms, unless the solicitation indicates otherwise. A facsimile, telegraphic, mailgram or electronic mail Offer shall be rejected if submitted in response to requests for proposals or invitations for bids.

2. Typed or Ink; Corrections. The Offer shall be typed or in ink. Erasures, interlineations or other modifications in the Offer shall be initialed in ink by the person signing the Offer. Modifications shall not be permitted after Offers have been opened except as otherwise provided under applicable law.

3. Evidence of Intent to be Bound. The Offer and Acceptance form within the Solicitation shall be submitted with the Offer and shall include a signature (or acknowledgement for electronic submissions, when authorized) by a person authorized to sign the Offer. The signature shall signify the Offeror's intent to be bound by the Offer and the terms of the Solicitation and that the information provided is true, accurate and complete. Failure to submit verifiable evidence of an intent to be bound, such as an original signature, shall result in rejection of the Offer.

4. Exceptions to Terms and Conditions. All exceptions included with the Offer shall be submitted in a clearly identified separate section of the Offer in which the Offeror clearly identifies the specific paragraphs of the Solicitation where the exceptions occur. Any exceptions not included in such a section shall be without force and effect in any resulting Contract unless such exception is specifically accepted by the Procurement Officer in a written statement. The Offeror's preprinted or standard terms will not be considered by the State as a part of any resulting Contract.

   i. Invitation for Bids. An Offer that takes exception to a material requirement of any part of the Solicitation, including terms and conditions, shall be rejected.

   ii. Request for Proposals. All exceptions that are contained in the Offer may negatively affect the State's proposal evaluation based on the evaluation criteria stated in the Solicitation or result in rejection of the Offer. An offer that takes exception to any material requirement of the solicitation may be rejected.

5. Subcontracts. Offeror shall clearly list any proposed subcontractors and the subcontractor's proposed responsibilities in the Offer.

6. Cost of Offer Preparation. The State will not reimburse any Offeror the cost of responding to a Solicitation.

7. Solicitation Amendments. Each Solicitation Amendment shall be signed with an original signature by the person signing the Offer, and shall be submitted no later than the Offer due date and time. Failure to return a signed copy of a Solicitation Amendment may result in rejection of the Offer.

8. Federal Excise Tax. The State of Arizona is exempt from certain Federal Excise Tax on manufactured goods. Exemption Certificates will be provided by the State.

9. Provision of Tax Identification Numbers. Offerors are required to provide their Arizona Transaction Privilege Tax Number and/or Federal Tax Identification number in the space provided on the Offer and Acceptance Form.

   9.1 Employee Identification. Offeror agrees to provide an employee identification number or social security number to the Department

for the purposes of reporting to appropriate taxing authorities, monies paid by the Department under this contract. If the federal identifier of the offeror is a social security number, this number is being requested solely for tax reporting purposes and will be shared only with appropriate state and federal officials.

This submission is mandatory under 26 U.S.C. § 6041A.

10. Identification of Taxes in Offer. The State of Arizona is subject to all applicable state and local transaction privilege taxes. All applicable taxes shall be included in the pricing offered in the solicitation. At all times, payment of taxes and the determination of applicable taxes are the sole responsibility of the contractor.

11. Disclosure. If the firm, business or person submitting this Offer has been debarred, suspended or otherwise lawfully precluded from participating in any public procurement activity, including being disapproved as a subcontractor with any Federal, state or local government, or if any such preclusion from participation from any public procurement activity is currently pending, the Offeror shall fully explain the circumstances relating to the preclusion or proposed preclusion in the Offer. The Offeror shall include a letter with its Offer setting forth the name and address of the governmental unit, the effective date of this suspension or debarment, the duration of the suspension or debarment, and the relevant circumstances relating to the suspension or debarment. If suspension or debarment is currently pending, a detailed description of all relevant circumstances including the details enumerated above shall be provided.

12. Solicitation Order of Precedence. In the event of a conflict in the provisions of this Solicitation, the following shall prevail in the order set forth below:

    12.1 Special Terms and Conditions;
    12.2 Uniform Terms and Conditions;
    12.3 Statement or Scope of Work;
    12.4 Specifications;
    12.5 Attachments;
    12.6 Exhibits;
    12.7 Special Instructions to Offerors;
    12.8 Uniform Instructions to Offerors.
    12.9 Other documents referenced or included in the Solicitation.

13. Delivery. Unless stated otherwise in the Solicitation, all prices shall be F.O.B. Destination and shall include all freight, delivery and unloading at the destination(s).

D. SUBMISSION OF OFFER

1. Sealed Envelope or Package. Each Offer shall be submitted to the submittal location identified in this Solicitation. Offers should be submitted in a sealed envelope or container. The envelope or container should be clearly identified with name of the Offeror and Solicitation number. The State may open envelopes or containers to identify contents if the envelope or container is not clearly identified.

2. Offer Amendment or Withdrawal. An Offer may not be amended or withdrawn after the Offer due date and time except as otherwise provided under applicable law.

3. Public Record. All Offers submitted and opened are public records and must be retained by the State. Offers shall be open to public inspection after Contract award, except for such Offers deemed to be confidential by the State. If an Offeror believes that information in its Offer should remain confidential, it shall indicate as confidential the specific information and submit a statement with its Offer detailing the reasons that the information should not be disclosed. Such reasons shall include the specific harm or prejudice which may arise. The State shall determine whether the identified information is confidential pursuant to the Arizona Procurement Code.

4. Non-collusion, Employment, and Services. By signing the Offer and Acceptance Form or other official contract form, the Offeror certifies that:

   i. The Offeror did not engage in collusion or other anti-competitive practices in connection with the preparation or submission of its Offer; and

   ii. The Offeror does not discriminate against any employee or applicant for employment or person to whom it provides services because of race, color, religion, sex, national origin, or disability, and that it complies with all applicable Federal, state and local laws and executive orders regarding employment.

E. EVALUATION

1. Unit Price Prevails. In the case of discrepancy between the unit price or rate and the extension of that unit price or rate, the unit price or rate shall govern.

2. Prompt Payment Discount. Prompt payment discounts of thirty (30) days or more set forth in an Offer shall be deducted from the offer for the purposes of evaluating that price.

3. Late Offers. An Offer submitted after the exact Offer due date and time shall be rejected.

4. Disqualification. A Offeror (including each of its' principals) who is currently debarred, suspended or otherwise lawfully prohibited from any public procurement activity shall have its offer rejected.

5. Offer Acceptance Period. An Offeror submitting an Offer under this Solicitation shall hold its Offer open for the number of days from the Offer due date that is stated in the Solicitation. If the Solicitation does not specifically state a number of days for Offer acceptance, the number of days shall be one hundred-twenty (120). If a Best and Final Offer is requested pursuant to a Request for Proposals, an Offeror shall hold its Offer open for one hundred-twenty (120) days from the Best and Final Offer due date.

5.6 Waiver and Rejection Rights. Notwithstanding any other provision of the Solicitation, the State reserves the right to:

5.6.1 Waive any minor informality;
5.6.2 Reject any and all Offers or portions thereof; or
5.6.3 Cancel the Solicitation.

F. AWARD

1. Number or Types of Awards. The State reserves the right to make multiple awards or to award a Contract by individual line items or alternatives, by group of line items or alternatives, or to make an aggregate award, or regional awards, whichever is most advantageous to the State. If the Procurement Officer determines that an aggregate award to one Offeror is not in the State's best interest, "all or none" Offers shall be rejected.

2. Contract Inception. An Offer does not constitute a Contract nor does it confer any rights on the Offeror to the award of a Contract. A Contract is not created until the Offer is accepted in writing by the Procurement Officer's signature on the Offer and Acceptance Form. A notice of award or of the intent to award shall not constitute acceptance of the Offer.

3. Effective Date**.** The effective date of this Contract shall be the date that the Procurement Officer signs the Offer and Acceptance form or other official contract form, unless another date is specifically stated in the Contract.

G. PROTESTS

A protest shall comply with and be resolved according to Arizona Revised Statutes Title 41, Chapter 23, Article 9 and rules adopted thereunder. Protests shall be in writing and be filed with both the Procurement Officer of the purchasing agency and with the State Procurement Administrator. A protest of a Solicitation shall be received by the Procurement Officer before the Offer due date. A protest of a proposed award or of an award shall be filed within ten (10) days after the protester knows or should have known the basis of the protest. A protest shall include:

1.1 The name, address and telephone number of the protester;
1.2 The signature of the protester or its representative;
1.3 Identification of the purchasing agency and the Solicitation or Contract number;
1.4 A detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and
1.5 The form of relief requested.

H. Comments Welcome

The State Procurement Office periodically reviews the Uniform Instructions to Offerors and welcomes any comments you may have. Please submit your comments to: State Procurement Administrator, State Procurement Office, 100 North 15th Avenue, Suite 104, Phoenix, Arizona, 85007.

SPECIAL INSTRUCTIONS

A. OFFER PERIOD (180 DAYS)

In order to allow for an adequate evaluation, the State requires an offer in response to this solicitation to be valid and irrevocable for one hundred-eighty (180) days after the opening time and date.

B. SUBMISSION OF INQUIRIES

In addition to the "Submission of Inquiries" section of the Uniform Instructions, the following shall apply:

In order to assist Arizona Department of Health Services (ADHS) in preparing for the Pre-Offer Conference, Offerors are encouraged to submit, in writing, any inquiries, clarifications or suggested changes to this Solicitation at least fourteen (14) days before the Pre-Offer Conference. Inquiries regarding the Solicitation will be received and considered less than fourteen (14) days before the Pre-Offer Conference date, but the contents may not be thoroughly considered in time to respond during the Pre-Offer Conference. This section does not limit or restrict an Offeror from asking questions or clarifying this Solicitation during the Pre-Offer Conference if written inquiries, questions, clarifications or suggested changes are not submitted. In addition to the paper copy of the inquiry delivered to the "Offer Delivery Location" address listed on the Cover Page of the Solicitation, an electronic copy, in Microsoft Word format, should be submitted to the following email address szawarr@azdhs.gov. ADHS will confirm receipt by e-mail. ADHS is not required to respond to inquiries in writing.

C. EXCEPTIONS TO TERMS AND CONDITIONS

In addition to the "Exceptions to the Terms and Conditions" section of the Uniform Instructions, the following shall apply:

An Offeror or vendor (the term "vendor" as used in this "EXCEPTIONS TO TERMS AND CONDITIONS" section is defined as an entity that has not submitted an Offer) may propose exceptions or substitutions to the Solicitation. Vendors may submit contemplated exceptions or substitutions before the Offer due date and vendors are encouraged to submit them, if any, not less than ten (10) days before the Offer due date. Submitting contemplated exceptions or

substitutions will permit ADHS to consider them relative to the potential impact to the Solicitation and determine if a Solicitation Amendment is necessary. If ADHS does not issue a written Solicitation Amendment for a vendor's contemplated exception or substitution prior to the Offer due date, the contemplated exception or substitution has not been accepted by ADHS.

Contemplated exceptions or substitutions submitted prior to the Offer due date will only be considered prior to the Offer due date and will not be considered after the Offer due date unless also submitted with the Offer. ADHS is not obligated to respond to a request to consider exceptions or substitutions prior to the Offer due date. ADHS is not obligated to negotiate exceptions or substitutions.

If submitting contemplated exceptions or substitutions as a vendor, or exceptions or substitutions as an Offeror, each exception or substitution, if any, should be clearly identified by proposing specific word changes in an interlineated format that has added text underlined and deleted text crossed out.

Contemplated exceptions or substitutions submitted prior to the offer due date should be submitted electronically, in Microsoft Word format to the following e-mail address: szawarr@azdhs.gov. ADHS will confirm receipt by e-mail. If submitting an exception or substitution with the Offer it should be submitted in accordance with the "Exceptions to Terms and Conditions" section of the Uniform Instructions to Offerors (Section C.4).

If an Offeror submits an exception or substitution with the offer and the Offeror is subsequently awarded a Contract and acceptance of the exception or substitution is not acknowledged by ADHS in the Acceptance of Offer and Contract Award notice; the Contractor shall be bound to perform the Contract without the exception or substitution in effect. No exception or substitution submitted is binding upon ADHS until ADHS acknowledges acceptance of the exception or substitution in writing. Offerors should carefully consider that exceptions or substitutions may result in rejection of the Offer.

The Uniform Instructions to Offerors, "Exceptions to Terms and Conditions," Section C.4, the sentence that reads: "Any exceptions not included in such a section shall be without force and effect in any resulting Contract unless such exception is specifically accepted by the Procurement Officer in a written statement" is modified to delete the words "not included in such a section"; therefore, this sentence is amended to read: "Any exceptions shall be without force and effect in any resulting Contract unless such exception is specifically accepted by the Procurement Officer in a written statement."

D. PRE-OFFER CONFERENCE

A Pre-Offer Conference has been scheduled for the date, time and location indicated on the Cover Page of this Solicitation. During the Pre-Offer Conference Offerors should be prepared to seek a response to any inquiries, clarifications or suggested changes submitted in writing in accordance with section "B. Submission of Inquiries" of these Special Instructions.

E. AMENDMENTS TO THE SOLICITATION

Inquiries from vendors submitted in accordance with the "Submission of Inquiries" sections of the Uniform and Special Instructions, and answers from ADHS, if any, will be issued as a Solicitation Amendment, and shall become part of this Solicitation. If ADHS deems it necessary to revise any part of this Solicitation before the proposal response date, ADHS will issue a Solicitation Amendment. ADHS shall not be bound by any verbal or written information that is not contained within the Solicitation or formally issued as a Solicitation Amendment by ADHS. Each Offeror shall be responsible to monitor the ADHS website for new or revised information as Solicitation Amendments may be issued at any time on the following website http://www.azdhs.gov/procurement/index.htm.

F. RESOURCES FOR DEVELOPING A PROPOSAL

The Bidder's Library contains critical reference material for developing a response to the RFP including, but not limited to, ADHS policies, manuals and guides; utilization data; and other information to assist the Offeror in preparing a thorough and realistic response to this Solicitation. References are made throughout this Solicitation to material in the Bidder's Library and on the ADHS website. Offerors are responsible for reviewing the contents of the Bidder's Library and ADHS website material as if they were printed in full herein. All such material is incorporated into the Contract by reference. Subsequent to the release of this RFP, ADHS anticipates posting to the Bidder's Library the program component of the Title XIX and Title XXI capitation rates as well as analyses of the impact of proposed rule changes referenced in Scope of Work section B.3.B. The Bidder's Library is located on the ADHS website at http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm

The Solicitation is posted in its entirety in both Adobe Acrobat PDF and MS Word formats on the ADHS Procurement website at: http://www.azdhs.gov/procurement/index.htm. The PDF version shall be the

official version of the Solicitation. The MS Word version is provided solely for the Offerors' convenience in developing a response to the Solicitation. If there are discrepancies between the PDF version of the Solicitation and the Offeror's response, the language of the PDF version of the Solicitation shall be controlling. The MS Word version of the Solicitation includes links to documents incorporated by reference into the Solicitation, and the Exhibits and Attachments (documents the Offeror should complete) to be downloaded and completed by the Offeror.

ADHS has established a secure section of the website for the RFP that contains data files redacted for protected health information. Prospective Offerors need to access and use the data files in order to fully respond to the RFP. To access the data files, ADHS has implemented a request process that is available to prospective Offerors during the hours of 8:00 am to 5:00 pm Arizona time, Monday through Friday. Prospective Offerors must request from ADHS a CRS RFP Nondisclosure of Protected Health Information Agreement (Nondisclosure Agreement) by sending a written request via e-mail to the following dedicated e-mail account: crsrfpdata@azdhs.gov .

Once ADHS receives the prospective Offeror's request for the Nondisclosure Agreement, ADHS will send the Nondisclosure Agreement to the prospective Offeror. The prospective Offeror must indicate agreement to the terms of the Nondisclosure Agreement by checking the I AGREE line at the bottom of the Nondisclosure Agreement, dating the I AGREE response and completing the required information on the Nondisclosure Agreement, i.e. the name and title of the person requesting access to the data files, the name and address of the prospective Offeror's agency or corporation, the requester's e-mail address and the phone number at which the requester can be reached. The prospective Offeror must then e-mail the completed Nondisclosure Agreement to crsrfpdata@azdhs.gov .

When ADHS receives the completed Nondisclosure Agreement, ADHS will review it for completeness, and if complete, will provide, by phone, a user name and password to the prospective Offeror to be used when accessing the secure website containing the redacted data files. ADHS will e-mail instructions to the prospective Offeror about how to access the secure website

G. BID BOND

The Offeror shall submit an irrevocable bid security payable to the State in the amount equal to fifty thousand dollars ($50,000.00). This security shall be in the form of a Bid Bond, certified check or cashier's check and must be in the possession of the State by the due date and time cited for this Solicitation.

The State will hold all bid security during the evaluation process. As soon as is practicable after the completion of the evaluation, the State will:

1. Issue an award notice for those offers accepted by the State.

2. Return all bond securities to those who have not been issued an award notice.

All bid security from Contractors who have been issued an award notice shall be held until the successful execution of all required contractual documents and bonds (e.g., performance bond, insurance). If the Contractor fails to execute the required contractual documents and bonds within the time specified, or ten (10) days after notice of award if no period is specified, the Contractor may be found to be in default and the Contract terminated by the State. In case of default, the State reserves all rights inclusive of, but not limited to, the right to purchase material and/or complete the work as required, in accordance with the Arizona Procurement Code (APC) and to recover any actual excess costs from the Contractor. Collection against the bid security shall be one of the measures available toward the recovery of any excess costs.

All bid bonds must be executed on forms substantially equivalent to State Procurement Office forms. An example of a bid bon form is provided in Exhibit G.

H. FEDERAL IMMIGRATION AND NATIONALITY ACT

By signing the Offer, the Offeror warrants that it and all proposed Subcontractors are in compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Offeror shall obtain statements from all proposed Subcontractors certifying compliance with this requirement and shall furnish the statements to the Procurement Officer upon request.

SPECIAL INSTRUCTIONS
SOLICITATION NO. HP832090

I. INFORMATION TECHNOLOGY 508 COMPLIANCE

Any electronic or Information Technology (IT) offered to the State of Arizona under this Solicitation shall comply with Arizona Revised Statutes (A.R.S.) §§41-2531 and 2532 and Section 508 of the Rehabilitation Act of 1973, which requires that employees and members of the public shall have access to and use of IT that is comparable to the access and use by employees and members of the public who are not individuals with disabilities. Any exceptions shall be declared in writing in the offer.

J. OFFSHORE PERFORMANCE OF WORK

Due to security and identity protection concerns, direct services under this Contract shall be performed within the borders of the US. Any services that are described in the specifications that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the US. Unless specifically stated otherwise in the specifications, this provision does not apply to indirect or 'overhead' services, redundant back-up services or services that are incidental to the performance of the Contract. This provision applies to work performed by Subcontractors at all tiers. Offerors shall declare all anticipated offshore services in the proposal.

K. PROPOSAL OPENING

Proposals will be opened publicly on the date, time and location indicated on the Cover Page of this Solicitation. Only the name of each Offeror shall be read publicly and recorded. Proposals shall not be subject to public inspection until after Contract Award.

Proposals will not be accepted via e-mail or facsimile transmission.

L. STATE DISCUSSIONS WITH OFFERORS

After the initial receipt of proposals, the State may conduct discussions with those Offerors who submit proposals determined to be in the competitive range or reasonably susceptible for award. The State is not required to negotiate; therefore, Offers should be complete and include the most favorable terms.

In conducting discussions, there will be no disclosure of any information derived from proposals submitted by other Offerors.

M. RESPONSIBILITY AND SUSCEPTIBILITY

The Agency Chief Procurement Officer will consider, but is not limited to, the following in determining an Offeror's responsibility as well as susceptibility to Contract Award:

1. whether the Offeror has had a contract within the last seven (7) years that was terminated for cause due to breach or similar failure to comply with the terms of the contract;

2. whether the Offeror's record of performance includes factual evidence of failure to satisfy the terms of the Offeror's agreements with any party to a contract. Factual evidence may consist of documented vendor performance reports, Customer complaints and/or negative references;

3. whether the Offeror is legally qualified to contract with the State;

4. whether the Offeror promptly supplied all requested information concerning its responsibility;

5. whether the Offer was sufficient to permit evaluation by ADHS, in accordance with the evaluation criteria identified in this Solicitation or other necessary offer components. Necessary offer components include: an indication of the intent to be bound, reasonable or acceptable approach to perform the Scope of Work, signed Solicitation Amendments, references, experience verification, adequacy of financial, business, personal or other resources and stability including subcontractors and any other data specifically requested in the Solicitation;

6. whether the Offer was in conformance with all the requirements contained in the Scope of Work, Terms and Conditions, and Instructions for the Solicitation and its Amendments, including the documents incorporated by reference;

7. whether the Offer limits the rights of ADHS or the State;

8. whether the Offer materially changes the Solicitation, which includes the Scope of Work, Terms and Conditions, or Instructions; or

9. whether the Offeror provides misleading or inaccurate information.

N. EVALUATION CRITERIA

In accordance with A.R.S. §41-2534, Competitive Sealed Proposals, awards shall be made to the responsible Offeror whose proposal is determined in writing to be the most advantageous to the State based upon the evaluation criteria listed below. The following evaluation criteria are consistent with the requirements of A.R.S. §36-261(d)(2) and listed in their relative order of importance. Within criteria 1. Technical Proposal, 1.A.1. and 1.A.2. are of equal weight and of higher relative importance than 1.B.1., 1.B.2., 1.B.3. and 1.B.4., which are of equal weight. Further, in criteria 2. Offeror's qualifications and demonstrated expertise, experience and capabilities including those related to the provision of pediatric services, 2.A., 2.B., and 2.C are of equal weight.

1. Technical proposal in the areas of:

   1.A.1. Managed Care and Service Delivery;
   1.A.2. Network Development and Management;

   1.B.1. Administration;
   1.B.2. Management Information Systems;
   1.B.3. Financial Management and Practices; and
   1.B.4. Implementation Plan.

2. Offeror's qualifications and demonstrated expertise, experience and capabilities, including those related to the provision of pediatric services, as evidenced by:

   2.A. Capacity to Perform;
   2.B. Organizational and Key Personnel Experience; and
   2.C. Past Performance.

3. Price (i.e., Costs to the State)

   The portion of the Title XIX and Title XXI capitation rates that is designated for the provision of Covered Services shall not be a factor in the proposal evaluation as ADHS has conducted an analysis and specified the capitation rates for Covered Services within this Solicitation. These rates are available in the Bidder's Library. In addition, the payment for delivery of Covered Services and performance of other Contractual requirements for Non-Title XIX and Non-Title XXI (State-only) populations shall not be a factor in the proposal evaluation. The State-only payment amount is specified in the Bidder's Library. Only the prices submitted by Offerors with the Price Sheet in Attachment B for the performance of

Contractual requirements associated with Title XIX and Title XXI Members, exclusive of the costs for Title XIX and Title XXI Covered Services, will be considered as a factor in the proposal evaluation.

Mercer Government Human Services Consulting, a part of Mercer Health & Benefits, LLC (Mercer) may assist ADHS with the evaluation of offers. ADHS will make the determination regarding Contract Award.

O. PROPOSAL FORMAT

One (1) original and ten (10) copies of each proposal shall be submitted in the format specified below. The original copy of the proposal should clearly be labeled "ORIGINAL," and all copies shall clearly state "COPY." In addition, the Offeror shall submit its proposal, including the Excel spreadsheet from the Bidder's Library (requested in section S.2.B.(5) of these Special Instructions and pictured in Attachment C), on eleven (11) compact discs (CDs) in Microsoft products. Each folder and file within each folder shall be clearly labeled. The State shall not provide any reimbursement for the cost of developing or presenting proposals in response to this Solicitation. Failure to include the requested information may have a negative impact on the evaluation of the Offeror's proposal. The proposal shall include at least the following information:

1. Proposals shall be prepared using a font size of no less than 12, including tables, on 8½ x 11 paper, single-spaced, double-sided, subject to any page limits specified. All pages of the proposal shall be page numbered sequentially. Each page shall be re-started with Line 1.

2. The Offeror shall organize proposal materials into high quality 3-ring binders, by subject matter, in the sequence specified and related to the Solicitation. The Offeror shall include a Table of Contents and number all pages in a consistent manner. Offerors shall create tab dividers for each of the sections included in section S. Proposal Content of these Special Instructions as listed below:

   A. Managed Care and Service Delivery;

   B. Network Development and Management;

   C. Administration;

   D. Management Information Systems;

E. Financial Management and Practices;

F. Implementation; and

G. Attachments Submitted in Response to the Request for Proposal.

P. RESPONDING TO THE SOLICITATION

Offerors should respond to the sections in section "S Proposal Content" of these Special Instructions in compliance with the following instructions:

1. Repeat each section reference number used in these Special Instructions, (e.g., S.2.A.(1).(a).i) and title heading, if one is used, before responding.

2. Respond to every section or state that the section is not applicable to your firm. Respond to every request for a document or state that a document request is not applicable to your firm.

3. Do not provide additional information unless requested to do so.

4. Do not reference separate materials unless specifically requested to provide sample documents as an Attachment or part of a response. All Attachments shall be submitted in a format acceptable to the State. Acceptable formats include .doc (Microsoft Word document), .xls (Microsoft Excel spreadsheet), or .pdf (Adobe Acrobat portable document format).

5. Limit your response to one (1) page unless otherwise specified.

Q. OFFER AND ACCEPTANCE SIGNED BY AUTHORIZED PERSON

Offeror must complete the top half of Attachment A "Offer and Acceptance" and submit the signed form with their proposal. Do not complete the "Acceptance of Offer" section of the form. By signing the Offer and Acceptance, the Offeror is agreeing to conform to all requirements contained in the Scope of Work, Terms and Conditions, and Instructions, including the requirements in all documents incorporated by reference, if awarded the Contract.

R. ON-SITE INSPECTION, REFERENCES AND EXPERIENCE VERIFICATION

ADHS may request on-site visits with Offeror(s) to obtain clarification of proposals and Offerors shall be available for on-site inspection of facilities as determined necessary by ADHS.

The Offeror agrees that by submitting an Offer, ADHS or its designated agent may contact any entity listed in the Offer or any entity known to have a previous business relationship with the Offeror for the purpose of obtaining references, verifying experience or other information submitted with the Offer. In addition, by submitting an Offer, the Offeror is agreeing to give permission to the identified Customer or entity to verify described experience and to take whatever action is necessary to encourage the Customer to provide the verification or release information.

S. PROPOSAL CONTENT

1. Managed Care and Service Delivery

   A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

      (1). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to manage government-funded services for children with CRS-related conditions as described in the Managed Care section of the Scope of Work.
      Limit three (3) pages.

      Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

      (2). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to arrange for the delivery of or provide multi-specialty, interdisciplinary pediatric heath care services to children with conditions similar to those addressed in the CRS program in a family-centered, culturally competent and linguistically appropriate

manner as described in the Service Delivery section of the Scope of Work.
Limit three (3) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Describe how the Managed Care functions identified in the Scope of Work would be organized. Provide a detailed organizational chart that identifies the number and titles of each position that will perform Managed Care functions (i.e., Quality Management (QM), Medical Management/Utilization Management (MM)/UM), Member Services and processing Grievances, Appeals and Claims Disputes). The organizational chart should include position titles, the number of Full Time Equivalents (FTEs) by position type, the geographic location of each position and whether the positions would be shared with other contracts or lines of business.
Limit two (2) pages exclusive of organizational charts.

ii. List Offeror's proposed staffing ratios (numbers of staff to Members), minimum educational requirements (e.g., high school, Bachelor of Arts degree, Master's degree, Medical degree), minimum licensure requirements (if applicable), and minimum years of experience for each of the positions listed below.

Position Title	Ratio of Staff to Members	Minimum Degree/License Required	Minimum Years of Experience Required
Member Service Reps			
Physicians that perform Managed Care functions			
Grievance and Appeals Processors			
Nurses that perform Managed Care functions			

iii. Describe how the Service Delivery functions will be organized. Provide a separate organizational chart that identifies the number and titles of each position that will provide Service delivery functions, exclusive of subcontracted providers, and inclusive of Eligibility and Enrollment services, Care Coordination, Transition Planning and Collaboration as described in the Scope of Work. The organizational chart should include position titles, the number of FTEs by position type, the geographic location of each position and whether the positions would be shared with other contracts or lines of business.
Limit two (2) pages exclusive of organizational chart.

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed key personnel and organizational staff that will provide Managed Care functions, documenting their educational and career history. Include expertise, experience and capabilities related to the delivery of pediatric services for children with conditions similar to those treated in the CRS program. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including

expertise, experience, education, capabilities and responsibilities for the position.
Limit job descriptions and resumes to three (3) pages each.

ii. Submit current resumes of proposed key personnel and organizational staff that will perform Service Delivery functions as defined in the Scope of Work, exclusive of subcontracted providers, documenting their educational and career history. Include expertise, experience and capabilities related to delivery of pediatric services for children with conditions similar to those addressed in the CRS program. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position.
Limit job descriptions and resumes to three (3) pages each.

(c). Past Performance

Respond to the following sections for the Offeror and its Management Services Subcontractors as currently constituted including any predecessor companies, companies the Offeror has acquired, and any parent, subsidiary or other affiliated companies.

i. Provide the number of eligibles for which the Offeror *delivered* government-funded health care services in the most recent two (2) calendar years, i.e., 2006 and 2007.

ii. Indicate whether the Offeror has had funds withheld or recouped, or has paid any performance penalties or financial sanctions related to Offeror's *delivery* of government-funded health care services in the most recent two (2) calendar years, i.e., 2006 and 2007.

If yes, list the date, the Customer(s), the amount, the reason for each penalty/sanction, the actions taken to improve performance and the time period elapsed to correct the deficiency that precipitated the penalty/sanction. Submit copies of the sanction or performance penalty letters and the plan(s) to correct the deficiencies.

iii. Provide the number of eligibles for which the Offeror *managed* government-funded health care services in the most recent two (2) calendar years, i.e., 2006 and 2007. Do not include eligibles for which the Offeror only delivered services.

iv. Indicate whether the Offeror has had funds withheld or recouped, or has paid any performance penalties or financial sanctions related to Offeror's *management* of government-funded health care services in the most recent two (2) calendar years, i.e., 2006 and 2007.

If yes, list the date, the Customer(s), the amount, the reason for each penalty/sanction, the actions taken to improve performance and the time period elapsed to correct the deficiency that precipitated the penalty/sanction. Submit copies of the sanction or performance penalty letters and the plan(s) to correct the deficiencies.

v. Indicate whether the Offeror has received a Notice to Cure, Corrective Action Plan (CAP), or other written notification that Offeror's *delivery* of government-funded health care services required correction in the most recent two (2) calendar years, i.e., 2006 and 2007. Include only those notifications that are not included in response to S.1.A.(3).(c)(ii and iv) above or S.1.A.(3)(c)vi below.

If yes, list the date, the Customer(s), reason for each notice/CAP/notification, the action(s) taken to cure and whether the actions taken to cure were sufficient to bring performance into compliance according to the Offeror and according to the Customer issuing the notice/CAP/notification. If multiple notices were received for the same concern/issue, provide information regarding each notice.

Include all system level and/or individual Member issues that resulted in a Customer requiring a CAP, sending a Notice to Cure, or other written notification of required performance correction to the Offeror to obtain satisfactory resolution. Do not include notices generated and resolved by the Offeror in response to a grievance, appeal or other regular quality improvement activity.

vi. Indicate whether the Offeror has received a Notice to Cure, Corrective Action Plan (CAP), or other written notification that Offeror's *management* of government-funded health care services required correction in the most recent two (2) calendar years, i.e., 2006 and 2007. Include only those notifications that are not included in response to S.1.A.(3).(c)(ii, iv and v) above.

If yes, list the date, the Customer(s), reason for each notice/CAP/notification, the action(s) taken to cure and whether the actions taken to cure were sufficient to bring performance into compliance according to the Offeror and according to the Customer issuing the notice/CAP/notification. If multiple notices were received for the same concern/issue, provide information regarding each notice.

Include all system level and/or individual Member issues that resulted in a Customer requiring a CAP, sending a Notice to Cure, or other written notification of required performance correction to the Offeror to obtain satisfactory resolution. Do not include notices generated and resolved by the Offeror in response to a grievance, appeal or other regular quality improvement activity.

vii. Indicate whether the Offeror has been required to take corrective action in response to a verified HIPAA complaint.

If yes, list the date, describe the nature of the complaint(s), corrective action(s) taken by Offeror and any additional corrective action required by the Office of Civil Rights (OCR). Also, indicate if civil monetary penalties or other sanctions were imposed.

viii. Indicate whether the Offeror has defaulted or has otherwise had a contract terminated for cause by a Customer within the past seven (7) years (i.e., 2001, 2002, 2003, 2004, 2005, 2006, and 2007). List the default or termination date, the Customer(s) name, and the reason for the default or termination for cause.

ix. State separately for each of the most recent two (2) calendar years, i.e., 2006 and 2007, the number of grievances and the number of grievances per 1,000 members of government-funded managed health care programs received by the Offeror.

x. State separately for each of the most recent two (2) calendar years, i.e., 2006, and 2007, the number of grievances and the number of grievances per 1,000 members received by the Offeror that were validated through investigation in whole or in part for your government-funded managed health care programs.

xi. State separately for each of the most recent two (2) calendar years, i.e., 2006 and 2007 the number and percentage of grievances resolved within thirty (30) days to the Member's satisfaction for government-funded managed health care programs.

xii. State separately for each of the most recent two (2) calendar years, i.e., 2006, and 2007, and rank in order from the greatest to least, the three (3) most common types of grievances received for your contracts with government-funded managed health care programs.

xiii. State separately for each of the most recent two (2) calendar years, i.e., 2006 and 2007, the volume of medical appeals and the appeal overturn rate in whole or in part for your government-funded managed health care programs.

xiv. State separately for each of the most recent two (2) calendar years, i.e., 2006 and 2007, the ratio of provider claims disputes to total claims processed. In addition, provide the percentage of provider claim dispute resolutions that were in favor of the Offeror that were overturned on appeal in whole or in part.

No page limits for each of i-xiv.

B. Managed Care Technical Proposal

(1). Quality Management

(a). Describe how the Offeror will conduct the QM program. Address the following:

i. Describe how QM will be monitored and conducted on a system-wide and individual case basis.

ii. Describe the method the Contractor will utilize to correct quality issues with delegated entities and/or subcontracted providers.

iii. Describe how the QM program will ensure that providers are appropriately credentialed and re-credentialed.

iv. Describe how the QM program will monitor, track and report on applicable Performance Measures, Performance Guarantees and Incentives.

v. Describe the Contractors' Peer Review process and how it will integrate with the QM Program.

vi. Describe how the QM Program will utilize data to support QI.

vii. Describe the QM Program workflow. Include the QM Committee structure, if applicable. Describe how the QM Program will coordinate with the MM/UM Program.

Limit ten (10) pages.

(b). Describe how the Offeror has used member and provider feedback (such as from satisfaction surveys and complaints) and/or provider profiling to identify problems and improve managed care and direct service delivery.
Limit two (2) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(c). Describe how the Offeror will ensure reports are based on complete and accurate data.
Limit two (2) pages.

(2). Medical Management/Utilization Management

(a). Describe how the Offeror will conduct the MM/UM program. Address the following:

i. Describe the MM/UM workflow for the authorization of care. Address how the authorization and review process will differ by level of care, service or equipment.

ii. Describe the ongoing monitoring protocols for MM/UM staff. Include the manner and frequency of supervision, documentation of audits, call monitoring and any other oversight activities.

iii. Describe the MM/UM workflow and processes for denials and appeals.

iv. Describe the methodology for identifying over- and under-utilization of services. Provide sample reports and describe how the information in those reports would be used.

v. Provide an example when the Offeror has detected under-utilization or over-utilization of services. Describe what was done to impact the utilization and how the effectiveness of the strategy was measured.

Limit ten (10) pages exclusive of flow charts and report samples.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(b). Describe the process for assuring that medical necessity and level of care guidelines are properly and consistently applied in the MM/UM process. Include a plan for determining inter-rater reliability of criteria application.
Limit three (3) pages.

(c). Describe the practice guidelines utilized by the Offeror's organization in managing care for children with conditions similar to those treated in the CRS program. Address the following:

i. Offeror's experience in utilizing practice guidelines provided by client organizations;
ii. Offeror's experience with a Practice Guideline applicable to CRS populations;
iii. Offeror's plan for assuring that Practice Guidelines required by this Contract are properly applied in the MM/UM process; and
iv. any additional practice guidelines the Offeror proposes for use by the CRS program.

Limit two (2) pages.

Identify the Customer(s) who can verify this experience described in response to i and ii above and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(3). Member Services

(a). Describe the Member Services workflow. Include the system for Member Service Representatives to respond to Member inquiries (e.g., regarding Eligibility and Enrollment, Grievances, Covered Services, etc.). Describe how the Offeror will assure accurate responses are provided to callers.
Limit two (2) pages.

(b). Describe how Member Services Representatives will assist with scheduling services provided in a Multi-specialty, Interdisciplinary Clinic (MSIC), Field Clinic or community-based (e.g., physician offices) settings.
Limit two (2) pages.

(4). Grievances, Appeals and Claim Disputes

(a). Describe how the Offeror will assure Members and their families have information about their rights, the information necessary to participate as decision-makers in treatment planning and to make choices about other important decisions such as Advance Directives and guardianship.
Limit two (2) pages.

(b). Describe how the Offeror will meet the Notice of Action (NOA), Notification of Extension of Timeframes for Service Authorization Decision (NOE), and other requirements related to denials, terminations, reduction, and suspension of services and appeals for the Title XIX and Title XXI Members. Provide proposed workflow, monitoring mechanisms, sample policy, IT system supports.
Limit two (2) pages, exclusive of sample policy.

C. Service Delivery Technical Proposal

(1). Describe the strategies the Offeror will use to educate and collaborate at a system level with other groups, organizations and agencies charged with the administration, support or delivery of services to children with special health care needs, such as the Arizona Health Care Cost Containment System (AHCCCS) Health Plans/Program Contractors, American Indian Health Program, hospitals, Arizona Rehabilitation Services Administration, the Local Education Agencies, and the Arizona Department of Economic Security (DES) Division of Developmental Disabilities (DDD), to coordinate care and identify potentially eligible children in need of CRS services who are not yet enrolled.
Limit three (3) pages.

(2). Describe how the Offeror will maintain information on race, ethnicity, preferred language of the Member and Member's family, Limited English Proficiency (LEP), and the need for alternative formats, and how the Offeror will use the information to meet Contractual requirements related to Service Delivery.
Limit two (2) pages.

(3). Describe the methods the Offeror will use to ensure its own and its Subcontractors' compliance with Contract requirements related to Service Delivery.
Limit two (2) pages.

(4). Describe how the Offeror will manage the Eligibility determination and Enrollment processes. Include a description of the proposed workflow. Address how the Offeror will ensure the appropriateness of Eligibility determinations.
Limit three (3) pages.

(5). Describe how and when Members will be offered a choice of provider.
Limit three (3) pages.

(6) Describe how the Offeror will ensure that an integrated medical record is maintained, consistent with Federal and State privacy laws, especially when services are provided in community settings. Describe any experience with maintaining an integrated medical record for a network-based delivery system.
Limit four (4) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(7). Describe the Offeror's plan to develop a centralized Service Plan accessible to providers, consistent with Federal and State privacy laws, that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation.
Limit three (3) pages.

2. Network Development and Management

A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

(1). Describe the Offeror's experience with strategies to develop and manage a network to deliver multi-specialty, interdisciplinary care for children with conditions similar to those addressed in the CRS program.
Limit four (4) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Describe how the Network Development and Network Management areas would be organized. Provide a detailed organizational chart that identifies the number and titles of each position that would conduct Network Development and Management functions as described in the Scope of Work. The organizational chart should include position titles, the number of FTEs by position type, the geographic location of each position and whether the positions would be shared with other contracts or lines of business.
Limit two (2) pages exclusive of organizational charts.

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed key personnel and organizational staff that will perform Network Development and Management functions as defined in the Scope of Work, documenting their educational and career history. Include expertise, experience and capabilities related to the development and management of a network that delivers pediatric services to children with conditions similar to those treated in the CRS program. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position.
Limit job descriptions and resumes to three (3) pages each.

(c). Past Performance
Network Access

i. State separately for each of the most recent two (2) calendar years, i.e., 2006 and 2007, the average number of days from the date of receipt of a request for an eligibility determination to the first appointment for a Member for your government-funded health care programs.

B. Network Development Technical Proposal

Describe your proposed design for the provider network. Provide the following:

(1). The types of settings the Offeror will use in the delivery of Covered Services, including MSICs, Field Clinics, community settings (e.g., provider offices) and any other strategies (e.g., Virtual clinics) that will be used to ensure efficient, convenient, high quality service delivery throughout Arizona.
Limit five (5) pages.

(2). A description of the Telemedicine system and how it will be used to improve access to care for Members and to improve the efficient utilization of providers in the Contractor's network.
Limit two (2) pages.

(3). A description of the geographic dispersion of the settings described in B.(1). above relative to Members and a plan to serve the urban, suburban and rural areas of Arizona. Provide the performance measures and evaluation methodologies the Offeror will use to ensure adequate access.
Limit four (4) pages.

(4). A plan for providing community-based services for therapies, pharmacy, laboratory and diagnostic services.
Limit two (2) pages

(5). A list of the non-hospital providers with whom the Offeror has a signed subcontract or a signed letter of intent to provide services under this Contract. The Offeror should download and complete the Excel spreadsheet from the Bidder's Library. Where provided in the spreadsheet, use the drop down menu to populate the cell. A picture of the spreadsheet is provided in Attachment C. The completed spreadsheet shall be submitted on the CD with the proposal. The Offeror should not submit a paper copy of the spreadsheet.
No page limit.

(6). A list of the hospitals with which the Offeror has subcontracted or has signed letters of intent and the expected utilization for each hospital. Describe the assumptions upon which the Member distribution across hospitals is based.
Limit two (2) pages.

(7). A list of the gaps that exist in the proposed network and the Offeror's proposed strategies to develop the network to close the gaps.
Limit two (2) pages.

C. Network Management Technical Proposal

(1). Describe how the Offeror will ensure Appointment Access Standards are met. Address the following:

(a). How the Offeror will secure sufficient numbers of provider contracts to ensure Appointment Access Standards identified in section D.1.E.(1) of the Score of Work will be met beginning on October 1, 2008.

(b). The anticipated barriers to sufficient appointment availability on October 1, 2008.

(c). Strategies the Offeror proposes to address these appointment availability barriers. Identify two strategies used in the past to improve access that have been successful.
Limit three (3) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(2). Describe the specific strategies the Offeror has used and will use to recruit and retain providers to assure the network will meet the needs of a diverse population for culturally appropriate care. Provide two (2) examples of a strategy that has worked in the past.
Limit three (3) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(3). Provide the subcontract templates for individual providers and facilities that incorporate all required elements.
No page limit.

(4). Describe how the Offeror will encourage continued participation by current CRS network providers during any Contract transition and throughout the Contract term.
Limit two (2) pages

(5). Provide a provider network communication plan that addresses:

(a). media to be used to communicate with the provider network;
(b). the frequency of regular contact with providers, if any;
(c). a description of the new provider orientation; and
(d). a description of the ongoing provider education program.

Limit three (3) pages

(6). Provide a description of how the Offeror will monitor the network's adequacy and sufficiency.
Limit three (3) pages.

(7). Describe actions the Offeror has taken when the results of network adequacy and sufficiency measures indicated a problem:

(a). With the overall network: Give two (2) examples of successful interventions and their impact on network adequacy and sufficiency.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(b). With a specific provider: Give two (2) examples of successful interventions and their impact on access to a specific provider. Each example should describe a situation with a different provider type.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

Limit four (4) pages.

(8). Describe how the Offeror will encourage independent Subcontractors, such as physicians, to either provide services in a MSIC or Field Clinic; and, if services are provided in an office setting, how the Offeror will encourage providers to coordinate care, keeping Members' needs and convenience primary.
Limit two (2) pages.

3. Administration

A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

(1). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to administer government-funded services as described in the Administration section of the Scope of Work, including but not limited to, hiring and retaining of Key Personnel, Organizational Staff and other staff; corporate compliance; training; and business continuity plans.
Limit three (3) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Using the grid below, list the proposed location(s) to administer all of the functions required by this Contract. Identify, at a minimum, all required Managed Care, Service Delivery, Network Development and Management, Administrative, MIS, and Financial and Implementation functions by location (exclusive of subcontracted direct service providers). Repeat the grid as necessary if multiple locations will be used.

Include any Management Services Subcontractors functions.

Service Center Location	
Name of Location	
Address	
City, State, Zip	
Telephone Number	
Type(s) of Service(s)	

ii. Indicate hours of operation for each location listed above using the grid below.

	Hours			
Day	From		To	
Monday through Friday		am/pm		am/pm
Saturday		am/pm		am/pm
Sunday		am/pm		am/pm
Holidays		am/pm		am/pm

iii. Describe the organizational structure and submit Offeror's organizational charts that show:

1). the number and titles of each position that will perform Administrative functions as described in the Scope of Work;

2). the position titles, the number of FTEs by position type, the geographic location of each Administrative position and whether the positions would be shared with other contracts or lines of business;

3). corporate structure, if applicable, and lines of responsibility and authority for all of the functions of this Contract;

4). local organizational structure for each work unit/department, that includes Key Personnel and Organizational Staff as described in the Contract;

6). if the Offeror is proposing to use Subcontractor(s) for any Management Services, show how oversight of the Management Services Subcontractor will be structured, including the primary individuals responsible for overseeing each Management Services Subcontractor.

Limit two (2) pages exclusive of organizational structure.

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed Key Personnel, Organizational Staff, and other Administrative staff, documenting their educational and career history. If proposed Key Personnel and Organizational Staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position. Limit each resume or job description to three (3) pages.

ii. Indicate the Contractor's agreement that the Contractor shall not include in its organization, any individual or entity that has been excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act. Disclosure shall be in accordance with the "Uniform Instructions" Section "C.(11) Disclosure."

iii. Indicate whether the Offeror's current key personnel have been arrested, charged with or convicted of a felony in the most recent five (5) calendar years, i.e., 2003, 2004, 2005, 2006 or 2007.

If yes, identify the key personnel and describe the arrest, charges and type of felony and the outcome.

iv. Indicate whether any proposed Key Personnel or Organizational Staff have been arrested, charged with or convicted of a felony in the most recent five (5) calendar years, i.e., 2003, 2004, 2005, 2006 or 2007.

If yes, identify the Key Personnel or Organizational Staff and describe the arrest, charges and type of felony and the outcome.

(c). Past Performance

i. Complete the chart below for up to five (5) of the largest (as defined by the number of eligibles) government-funded contracts held by the Offeror (or parent organization) that included the provision or management of services to children with conditions similar to those treated in the CRS program.

Customer Name	Total Number of Eligible Members	Approximate Annual Revenue in Most Recent Year of Contract	Nature of Contract/Form of Payment (e.g., full cap, cap w/ risk corridors, ASO fee)	Direct Contract with Agency or Through Health Plan	Populations Served (e.g., Title XIX, Title XXI, Non-Title XIX/XXI, children with a CRS-like Condition)	Number of Years Offeror (has) Held Contract	Contract is Active or Terminated

ii. Identify the year in which the Offeror first delivered health care services to government-funded members.

iii. Identify the year in which the Offeror first managed health care services for government-funded members.

iv. Describe the ownership/tax status of Offeror's organization (e.g., private/for-profit).

v. List the names of all persons or entities with a five percent (5%) or greater ownership interest in Offeror's organization.

B. Administration Technical Proposal

(1). Identify any entity, including a parent, subsidiary, affiliate, or other related organization, the Offeror intends to subcontract with for administrative or Management Services. Submit the following information regarding proposed Management Services Subcontractors:

(a). name, address, and telephone number of the Subcontractor;

(b). ownership of the organization;

(c). specific Management Service(s) that will be subcontracted;

(d). the years of the Subcontractor's relevant Management Services experience;

(e). the number of years the subcontract(s) for these services has been in place between the Subcontractor and Offeror's organization, if applicable;

(f). the positions and hours that are expected to be provided on an annual basis;

(g). the proposed compensation arrangement, including total estimated annual Subcontractor compensation;

(h). indicate that the Subcontractor, its employees, and consultants have never been debarred, suspended or excluded from any Federal or State program. Disclosure shall be in accordance with the "Uniform Instructions" Section "C.(11) Disclosure"; and

(i). a copy of the Management Services subcontracts or proposed subcontracts the Offeror will have with a Management Services Subcontractor.

Limit five (5) pages per Subcontractor arrangement, excluding copies of the subcontracts.

(2). Indicate that the Offeror agrees to obtain the required Arizona business license if awarded a Contract.

(3). Indicate whether the Offeror or any parent, subsidiary or affiliate company filed for bankruptcy in the most recent five (5) calendar years, i.e., 2003, 2004, 2005, 2006 or 2007.

If yes, describe the impact on current operations.

(4). Indicate if the Offeror, the Offeror's key personnel or the proposed Key Personnel have been named as a party to any litigation pending or resolved in the most recent five (5) calendar years, i.e., 2003, 2004, 2005, 2006 or 2007?

If yes and the litigation relates to Offeror's ability/qualifications to perform the services described in this Contract, provide a description of the litigation and its outcome.

(5). Describe the fraud and abuse program the Offeror would propose for this Contract. Include a description of the internal controls the Offeror will have for Contractor's personnel, providers, and Members. Describe the Offeror's experience with implementing a comprehensive fraud and abuse monitoring program. Provide two (2) examples of fraud or abuse the Offeror has detected and what Offeror did upon detection.
Limit four (4) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(6). Identify any accreditations the Offeror holds. List the name of the accrediting body, the date by which accreditation was first achieved and subsequent renewal dates, the line of business and geographic location for which the accreditation is applicable, and whether the accreditation would be applicable to the operations of this Contract, if awarded.
No page limit.

4. Management Information Systems

A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

(1). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to perform the requirements described in the Management Information Systems section of the Scope of Work.
Limit two (2) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Describe how the IT and claims/encounter staff functions would be organized. Provide a detailed organizational chart that identifies the number and titles of each position that will perform Management Information Services as described in the Scope of Work. The organizational chart should include position titles, the number of FTEs by position type, the geographic location of each position and whether the positions would be shared with other contracts or lines of business.

Limit two (2) pages exclusive of organizational charts.

ii. Describe how IT and claims/encounter personnel would be trained.
Limit two (2) pages

iii. List Offeror's proposed staffing ratios (numbers of staff to members), minimum educational requirements (e.g., high school, BA, masters, MD), minimum licensure requirements (where applicable), and minimum years of experience for the claims and encounter processors below.

Position Title	Ratio of Staff to Members	Minimum Education/License Required	Minimum Years of Experience Required
Claims/Encounter Processors			

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed key personnel and organizational staff that will provide MIS requirements. Include education, expertise, experience and capabilities. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position.
Limit job descriptions and resumes to three (3) pages each.

(c). Past Performance

i. Provide claim submission statistics for December 2007, for electronic and paper submissions. All formats, including proprietary formats, must be included.

Claim Type	Number Received
CMS UB 92 (paper)	
CMS 1500 (paper)	
HIPAA 837I (Institutional)	
HIPAA 837P (Professional)	
NCPDP	
Other (list)	

ii. Provide a list of scheduled and unscheduled downtime from January 1, 2007 through December 31, 2007 including the duration of downtime, the systems or software affected, and the reason for downtime. Indicate if there are parallel system environments available for development, testing (quality assurance), and productions environments.
Limit three (3) pages.

iii. Provide percentages in the grid below for claims payment performance for Offeror's government-funded managed health care Customers for calendar years 2006 and 2007.

	2006	2007
Accuracy		
Financial Payment Accuracy (Dollars)[1]		
Payment Incidence Accuracy Rate[2]		
Overall Procedural Accuracy Rate[3]		
Claims Timeliness		
% paid within 0 to 14 calendar days		
% paid within 0 to 30 calendar days		

1. *Financial Accuracy is calculated as the total audited "paid" dollars minus the absolute value of over- and/or under-payments, divided by the total audited paid dollars.*
2. *Payment Incidence Accuracy means the total number of audited claims (pays and no pays) processed free of financial error divided by the total number of audited claims. Error is defined as any error regardless of cause (e.g., coding, procedural, system), that results in incorrect payment. Each type of error is counted as one full error, and no more than one error can be assigned to one claim.*
3. *Overall Procedural Accuracy means the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims Error is defined as any error, regardless of cause (e.g., coding, procedural, system) whether or not it results in an incorrect payment. Each type of error is counted as one full error, and no more than one error can be assigned to one claim.*

B. Management Information Systems Technical Proposal

(1). Describe Offeror's hardware and platform on which the software runs. Describe the facility in which the processor is or will be located, including environmental and security safeguards.
Limit five (5) pages.

(2). Describe Offeror's software systems used to coordinate managed care, encounter reporting, and claims payment functions.
Limit three (3) pages.

(3). Provide a list of edits available for claims payment configuration and the proposed disposition settings for each edit.
Limit twelve (12) pages.

(4). Describe Offeror's operating system/network infrastructure on which the software runs. Describe the programming language utilized and the software used to develop it. Describe how the source code could be purchased so Offeror can customize the software. Describe Offeror's policy and procedure on software upgrades.
Limit five (5) pages.

(5). Describe how Offeror's information systems are compatible or will become compatible with systems used by CRS providers.
Limit three (3) pages.

(6). Describe the Offeror's system ability to provide an electronic data interface to allow transfer of HIPAA compliant information from and to ADHS, including software used. Include the transfer of eligibility and encounter data in the Offeror's response.
Limit three (3) pages.

(7). Describe the Offeror's ability to send and receive data that may be in proprietary formats.
Limit five (5) pages.

(8). Provide a network configuration and architecture drawing of how workstations would be connected to the system, including Internet, Intranet, and Extranet, Wide Area and Local Area Networks.
Limit five (5) pages.

(9). Describe how subcontracted providers would be trained on data submission requirements including at a minimum, demographic and claims/encounter data.
Limit three (3) pages.

(10). Describe Offeror's system data archive and retrieval system as well as disaster recovery procedures. Include the most recent use of the data retrieval system and describe the outcome. Indicate if disaster recovery procedures have been used or tested and describe the outcomes.
Limit six (6) pages.

(11). Describe Offeror's system security and audit functions. Include physical and system security procedures, role-based security protocols, and systematic claims audit capabilities and functions utilized.
Limit ten (10) pages.

(12). Provide a narrative for how the Offeror will become compliant with all CRS proprietary file layouts. Provide a data map between the data elements described in the CRS File Layout and Specification Manual and the data elements captured, stored and used by the proposed system. Identify any limitations on, or required modifications to, the captured data elements, such as field lengths. For any of the data elements listed that are not currently captured, stored, or used, indicate the capability to do so. Additionally, provide the Offeror's proposed plan for testing and transferring ADHS data into the Offeror's system.
Limit thirty (30) pages.

(13). Provide a claims data flow diagram from the time a claim enters the building via paper and/or EDI to final adjudication and payment. Limit four (4) pages.

(14). Provide a listing of the Offeror's most recent standard claims management reports and a description of how they are currently used to track claims processes and ensure claims payments are accurate, timely and complete (e.g., claims turnaround times, pended claims, inventory).
Limit three (3) pages.

(15). Describe the Offeror's internal claims auditing functions. Include overall percentage of claims audited as well as dollar threshold audit requirements. Provide statistics from 2006 and 2007 on audit outcomes related to internal claims auditing efforts.
Limit five (5) pages.

(16). Describe Offeror's experience with submitting and receiving 834 Enrollment/Disenrollment transaction sets. Also discuss Offeror's experience submitting Medicaid encounters in 837 and NCPDP formats to government agencies and discuss compliance issues with timeliness, accuracy, and volume requirements. Limit six (6) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

5. Financial Management and Practices

A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

(1). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to perform the functions described in the Financial Management and Practices section of the Scope of Work.
Limit two (2) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Describe how the financial management and practices staff functions would be organized. Provide a detailed organizational chart that identifies the number and titles of each position that will perform Financial Management and Practices as described in the Scope of Work. The organizational chart should include position titles, the number of FTEs by position type, the geographic location of each position and whether the positions would be shared with other contracts or lines of business.
Limit one (1) page exclusive of organizational charts.

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed key personnel and organizational staff that will provide Financial Management and Practices. Include education, expertise, experience and capabilities. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position.
Limit job descriptions and resumes to three (3) pages each.

(c). Past Performance

i. Submit the Offeror's audited financial statements that cover the two (2) most recent years and the most recent unaudited quarterly financial statements (year-to-date). If the Offeror is a newly formed corporation and does not have any audited financial statements, submit the most recent annual audited (to cover the most recent two (2) years) and quarterly unaudited financial statements of the

corporation(s) that intends to provide funding or support to the newly formed corporation. Disclose the relationships of the corporation(s) to the Offeror.
Limit one (1) page, excluding the audited financial statements.

B. Financial Management and Practices Technical Proposal

(1). Describe the Offeror's experience tracking and reporting revenues, services and administrative expenditures at the rate cell/population subgroup level. Provide an example of such historical reporting on a quarterly and annual basis.
Limit two (2) pages, excluding the example reports.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(2). Indicate if the Offeror currently has accounting systems that identify expenditures at the rate cell level. If not, identify how these systems will be developed.
Limit two (2) pages.

(3). Explain how the Offeror will ensure accurate and timely reporting of encounters/claims from their provider network. Include a description of how the Offeror will resolve encounter reporting issues with their provider network in a timely manner.
Limit two (2) pages.

(4). Describe how the Offeror will contain costs while promoting access to care and delivery of high quality health care services.
Limit four (4) pages.

(5). Confirm that the Offeror agrees to have in place within thirty (30) days of the Contract Award date, initial capitalization in the amount of $5,000,000, which is met with no encumbrances, such as loans subject to repayment. The initial capitalization may be applied toward meeting any

future equity per Member requirement and is intended for use in the operations of the Contractor.

Describe in detail how this requirement will be met. If the Offeror is relying on other organization(s) to meet the initial minimum capitalization requirement, submit the most recent audited financial statements of the other organization(s). Describe the specific relationship between the Offeror and the other organization(s). In addition, in this case, submit a written certification, signed and dated by the President/Chief Executive Officer (CEO) of the other organization(s), indicating the organization(s)' intent to provide the initial minimum capitalization to the Offeror, without restrictions, within the time frame contained in the Contract.
Limit three (3) pages.

6. Implementation

A. Offeror's Qualifications and Demonstrated Expertise, Experience and Capabilities

(1). Describe the Offeror's qualifications and demonstrated expertise, experience and capabilities to implement this Contract as described in the Implementation section of the Scope of Work and section "K. Transition and Implementation" of the Special Terms and Conditions.
Limit two (2) pages.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

(a). Capacity to Perform

i. Identify the FTEs who would be assigned during any transition and Implementation period using the following grid.
* Check boxes that apply

Name	Years with Organization	Title/Role	FTE	Transition*	Implementation*	Both*

(b). Organizational and Key Personnel Experience

i. Submit current resumes of proposed key personnel and organizational staff that will conduct the Implementation. Include expertise, experience and capabilities. If proposed key personnel and organizational staff are not yet identified, submit job descriptions outlining the minimum qualifications of the position(s), including expertise, experience, education, capabilities and responsibilities for the position. Limit job descriptions and resumes to three (3) pages each.

(c). Past Performance

i. Provide a copy of an implementation plan that Offeror has used for another government/public sector Customer, outlining tasks necessary to implement the program, the timetable and the parties responsible.

Identify the Customer(s) who can verify this experience and provide current contact information, including the name, phone number and position of the individual who can provide the verification.

ii. Describe the three (3) most important lessons the Offeror has learned from a government/public sector Customer contract implementation in the most recent three (3) calendar years, i.e., 2005, 2006 or 2007 that will affect the Implementation Plan Offeror designed for this Contract. At least one (1) of the lessons should relate to IT or claims/encounter processing.
Limit three (3) pages.

B. Implementation Technical Proposal

(1). Provide a copy of the implementation plan that the Offeror proposes for this Contract, outlining tasks necessary to implement the program, including at a minimum, those tasks identified in Exhibit F, the timetable, and the parties responsible.
Limit five (5) pages.

7. Price (i.e., Costs to the State)

Confirm the Offeror's acceptance of a) the Title XIX and Title XXI capitation rates for delivery of Covered Services, which are provided in the Bidder's Library; b) the Non-Title XIX and Non-Title XXI payment amount, which is provided in the Bidder's Library and includes payments for both the delivery of Covered Services and all other Contractual requirements associated with Non-Title XIX and Non-Title XXI (State-only) Members; and c) the compensation terms outlined in section "G. Financial Management and Practices" of the Scope of Work for Title XIX, Title XIX, Non-Title XIX and Non-Title XXI (State-only) populations, which are all subject to change as described in the Special Terms and Conditions section "A.6. Price Increases or Decreases".

Using Attachment B, Price Sheet, submit Offeror's PMPM bid amount to perform the Contractual requirements associated with Title XIX and Title XXI populations, exclusive of costs associated with delivery of Covered Services, if the Contractor's total membership was 8,000 Members and if the Contractors' total membership was 16,000 Members.

UNIFORM TERMS AND CONDITIONS

1. *Definition of Terms*. As used in this Solicitation and any resulting Contract, the terms listed below are defined as follows:

1.1 *"Attachment"* means any item the Solicitation requires the Offeror to submit as part of the Offer.

1.2 *"Contract"* means the combination of the Solicitation, including the Uniform and Special Instructions to Offerors, the Uniform and Special Terms and Conditions, and the Specifications and Statement or Scope of Work; the Offer and any Best and Final Offers; and any Solicitation Amendments or Contract Amendments.

1.3 "*Contract Amendment*" means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.

1.4 *"Contractor"* means any person who has a Contract with the State.

1.5 *"Days"* means calendar days unless otherwise specified.

1.6 *"Exhibit"* means any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.

1.7 *"Gratuity"* means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

1.8 "*Materials"* means all property, including equipment, supplies, printing, insurance and leases of property but does not include land, a permanent interest in land or real property or leasing space.

1.9 *"Procurement Officer"* means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

1.10 *"Services"* means the furnishing of labor, time or effort by a contractor or subcontractor which does not involve the delivery of a specific end product other than required reports and performance, but does not include employment agreements or collective bargaining agreements.

1.11 *"Subcontract"* means any Contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.

1.12 *"State"* means the State of Arizona and Department or Agency of the State that executes the Contract.

1.13 *"State Fiscal Year"* means the period beginning with July 1 and ending June 30,

2. Contract Interpretation

2.1 Arizona Law. The Arizona law applies to this Contract including, where applicable, the Uniform Commercial Code as adopted by the State of Arizona and the Arizona Procurement Code, Arizona Revised Statutes (A.R.S.) Title 41, Chapter 23, and its implementing rules, Arizona Administrative Code (A.A.C.) Title 2, Chapter 7.

2.2 Implied Contract Terms. Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it.

2.3 Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

2.3.1 Special Terms and Conditions;
2.3.2 Uniform Terms and Conditions;
2.3.3 Statement or Scope of Work;
2.3.4 Specifications;
2.3.5 Attachments;
2.3.6 Exhibits;
2.3.7 Documents referenced or included in the Solicitation.

2.4 Relationship of Parties. The Contractor under this Contract is an independent Contractor. Neither party to this Contract shall be deemed to be the employee or agent of the other party to the Contract.

2.5 Severability. The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract.

2.6 No Parol Evidence. This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document and no other understanding either oral or in writing shall be binding.

2.7 No Waiver. Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

3. Contract administration and operation.

3.1 Records. Under A.R.S. § 35-214 and § 35-215, the Contractor shall retain and shall contractually require each subcontractor to retain all data and other "records" relating to the acquisition and performance of the Contract for a period of five years after the completion of the Contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records.

3.2 Non-Discrimination. The Contractor shall comply with State Executive Order No. 99-4 and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act.

3.3 Audit. Pursuant to A.R.S. § 35-214, at any time during the term of this Contract and five (5) years thereafter, the Contractor's or any subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract.

3.4 Facilities Inspection and Materials Testing. The Contractor agrees to permit access to its facilities, subcontractor facilities and the Contractor's processes or services, at reasonable times for inspection of the facilities or materials covered under this Contract. The State shall also have the right to test, at its own cost, the materials to be supplied under this Contract. Neither inspection of the Contractor's facilities nor materials testing shall constitute final acceptance of the materials or services. If the State determines noncompliance of the materials, the Contractor shall be responsible for the payment of all costs incurred by the State for testing and inspection.

3.5 Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the Offer and Acceptance form submitted by the Contractor unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to the Solicitation Contact Person indicated on the Solicitation cover sheet, unless otherwise stated in the Contract. An authorized Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice to the other and an amendment to the Contract shall not be necessary.

3.6 Advertising, Publishing and Promotion of Contract. The Contractor shall not use, advertise or promote information for commercial benefit concerning this Contract without the prior written approval of the Procurement Officer.

3.7 Property of the State. Any materials, including reports, computer programs and other deliverables, created under this Contract are the sole property of the State. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of the State.

3.8 Ownership of Intellectual Property. Any and all intellectual property, including but not limited to copyright, invention, trademark, trade name, service mark, and/or trade secrets created or conceived pursuant to or as a result of this contract and any related subcontract ("Intellectual Property"), shall be work made for hire and the State shall be considered the creator of such Intellectual Property. The agency, department, division, board or commission of the State of Arizona requesting the issuance of the contract shall own (for and on behalf of the State) the entire right, title and interest to the Intellectual Property throughout the world. Contractor shall notify the State, within thirty (30) days, of the creation of any Intellectual Property by it or its subcontractor(s). Contractor, on behalf of itself and any subcontractor (s), agrees to execute any and all document(s) necessary to assure ownership of the Intellectual Property vests in the State and shall take no affirmative actions that might have the effect of vesting all or part of the Intellectual Property in any entity other than the State. The Intellectual Property shall not be disclosed by contractor or its subcontractor(s) to any entity not the State without the express written authorization of the agency, department, division, board or commission of the State of Arizona requesting the issuance of this contract.

4. Costs and Payments

4.1 Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days.

4.2 Delivery. Unless stated otherwise in the Contract, all prices shall be F.O.B. Destination and shall include all freight delivery and unloading at the destination.

4.3 Applicable Taxes.

4.3.1 Payment of Taxes. The Contractor shall be responsible for paying all applicable taxes.

4.3.2 State and Local Transaction Privilege Taxes. The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure collect such taxes from the buyer does not relieve the seller from its obligation to remit taxes.

4.3.3 Tax Indemnification. Contractor and all subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall, and require all subcontractors to hold the State harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation.

4.3.4 IRS W9 Form. In order to receive payment the Contractor shall have a current IRS W9 Form on file with the State of Arizona, unless not required by law.

4.4 Availability of Funds for the Next State fiscal year. Funds may not presently be available for performance under this Contract beyond the current state fiscal year. No legal liability on the part of the State for any payment may arise under this Contract beyond the current state fiscal year until funds are made available for performance of this Contract.

4.5 Availability of Funds for the current State fiscal year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these goods or services are not funded, the State may take any of the following actions:

4.5.1 Accept a decrease in price offered by the, contractor
4.5.2 Cancel the Contract
4.5.3 Cancel the contract and re-solicit the requirements.

5. Contract changes

5.1 Amendments. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment within the scope of the Contract. Changes to the Contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by a person who is not specifically authorized by the procurement officer in writing or made unilaterally by the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized written Contract Amendments shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes.

5.2 Subcontracts. The Contractor shall not enter into any Subcontract under this Contract for the performance of this contract without the advance written approval of the Procurement Officer. The Contractor shall clearly list any proposed subcontractors and the subcontractor's proposed responsibilities. The Subcontract shall incorporate by reference the terms and conditions of this Contract.

5.3 Assignment and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

6. Risk and Liability

6.1 Risk of Loss. The Contractor shall bear all loss of conforming material covered under this Contract until received by authorized personnel at the location designated in the purchase order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming materials shall remain with the Contractor regardless of receipt.

6.2 Indemnification

6.2.1 Contractor/Vendor Indemnification (Not Public Agency) The parties to this contract agree that the State of Arizona, its' departments, agencies, boards and commissions shall be indemnified and held harmless by the contractor for the vicarious liability of the State as a result of entering into this contract. However, the parties further agree that the State of Arizona, its' departments, agencies, boards and commissions shall be responsible for its' own negligence. Each party to this contract is responsible for its' own negligence.

6.2.2 Public Agency Language Only Each party (as 'indemnitor') agrees to indemnify, defend, and hold harmless the other party (as 'indemnitee'') from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its' officers, officials, agents, employees, or volunteers."

6.3 Indemnification - Patent and Copyright**.** The Contractor shall indemnify and hold harmless the State against any liability, including costs and expenses, for infringement of any patent, trademark or copyright arising out of Contract performance or use by the State of materials furnished or work performed under this Contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph. If the contractor is insured pursuant to A.R.S. § 41-621 and § 35-154, this section shall not apply.

6.4 Force Majeure.

6.4.1 Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force majeure. The term *"force majeure"* means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; war; riots; strikes; mobilization; labor disputes; civil disorders; fire; flood; lockouts; injunctions-intervention-acts; or failures or refusals to act by government authority; and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence.

6.4.2 Force Majeure shall not include the following occurrences:

6.4.2.1 Late delivery of equipment or materials caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market;

6.4.2.2 Late performance by a subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition; or

6.4.2.3 Inability of either the Contractor or any subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

6.4.3 If either party is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day, of the commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that results or effects of such delay prevent the delayed party from performing in accordance with this Contract.

6.4.4 Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such delay or failure is caused by force majeure.

6.5 Third Party Antitrust Violations. The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor, toward fulfillment of this Contract.

7. Warranties

7.1 Liens. The Contractor warrants that the materials supplied under this Contract are free of liens and shall remain free of liens.

7.2 Quality. Unless otherwise modified elsewhere in these terms and conditions, the Contractor warrants that, for one year after acceptance by the State of the materials, they shall be:

7.2.1 Of a quality to pass without objection in the trade under the Contract description;
7.2.2 Fit for the intended purposes for which the materials are used;
7.2.3 Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units;
7.2.4 Adequately contained, packaged and marked as the Contract may require; and
7.2.5 Conform to the written promises or affirmations of fact made by the Contractor.

7.3 Fitness. The Contractor warrants that any material supplied to the State shall fully conform to all requirements of the Contract and all representations of the Contractor, and shall be fit for all purposes and uses required by the Contract.

7.4 Inspection/Testing. The warranties set forth in subparagraphs 7.1 through 7.3 of this paragraph are not affected by inspection or testing of or payment for the materials by the State.

7.5 Year 2000.

7.5.1 Notwithstanding any other warranty or disclaimer of warranty in this Contract, the Contractor warrants that all products delivered and all

services rendered under this Contract shall comply in all respects to performance and delivery requirements of the specifications and shall not be adversely affected by any date-related data Year 2000 issues. This warranty shall survive the expiration or termination of this Contract. In addition, the defense of *force majeure* shall not apply to the Contractor's failure to perform specification requirements as a result of any date-related data Year 2000 issues.

7.5.2 Additionally, notwithstanding any other warranty or disclaimer of warranty in this Contract, the Contractor warrants that each hardware, software, and firmware product delivered under this Contract shall be able to accurately process date/time data (including but not limited to calculation, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000 and leap year calculations, to the extent that other information technology utilized by the State in combination with the information technology being acquired under this Contract properly exchanges date-time data with it. If this Contract requires that the information technology products being acquired perform as a system, or that the information technology products being acquired perform as a system in combination with other State information technology, then this warranty shall apply to the acquired products as a system. The remedies available to the State for breach of this warranty shall include, but shall not be limited to, repair and replacement of the information technology products delivered under this Contract. In addition, the defense of *force majeure* shall not apply to the failure of the Contractor to perform any specification requirements as a result of any date-related data Year 2000 issues.

7.6 Compliance With Applicable Laws. The materials and services supplied under this Contract shall comply with all applicable Federal, state and local laws, and the Contractor shall maintain all applicable licenses and permit requirements.

7.7 Survival of Rights and Obligations after Contract Expiration or Termination.

7.71 Contractor's Representations and Warranties. All representations and warranties made by the Contractor under this Contract shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12-510, except as provided in A.R.S. § 12-529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S., Title 12, Chapter 5.

7.7.2 Purchase Orders. The Contractor shall, in accordance with all terms and conditions of the Contract, fully perform and shall be obligated to comply with all purchase orders received by the Contractor prior to the expiration or termination hereof, unless otherwise directed in writing by the Procurement Officer, including, without limitation, all purchase orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

8. State's Contractual Remedies

8.1 Right to Assurance. If the State in good faith has reason to believe that the Contractor does not intend to, or is unable to perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. Failure by the Contractor to provide written assurance within the number of Days specified in the demand may, at the State's option, be the basis for terminating the Contract under the Uniform Terms and Conditions or other rights and remedies available by law or provided by the contract.

8.2 Stop Work Order.

8.2.1 The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part, of the work called for by this Contract for period(s) of days indicated by the State after the order is delivered to the Contractor. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage.

8.2.2 If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall

resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

8.3 Non-exclusive Remedies. The rights and the remedies of the State under this Contract are not exclusive.

8.4 Nonconforming Tender. Materials or services supplied under this Contract shall fully comply with the Contract. The delivery of materials or services or a portion of the materials or services that do not fully comply constitutes a breach of contract. On delivery of nonconforming materials or services, the State may terminate the Contract for default under applicable termination clauses in the Contract, exercise any of its rights and remedies under the Uniform Commercial Code, or pursue any other right or remedy available to it.

8.5 Right of Offset. The State shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by the State, or damages assessed by the State concerning the Contractor's non-conforming performance or failure to perform the Contract, including expenses, costs and damages described in the Uniform Terms and Conditions.

9. Contract Termination

9.1 Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is or becomes at any time while the Contract or an extension of the Contract is in effect an employee of or a consultant to any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time. If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided in A.R.S. § 38-511.

9.2 Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State determines that employment or a Gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including the making of any determination or decision about contract performance. The State, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the Gratuity offered by the Contractor.

9.3 Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that the contractor is not currently suspended or debarred. If the contractor becomes suspended or debarred, the contractor shall immediately notify the State.

9.4 Termination for Convenience. The State reserves the right to terminate the Contract, in whole or in part at any time, when in the best interests of the State without penalty or recourse. Upon receipt of the written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination. The cost principles and procedures provided in A.A.C. R2-7-701 shall apply.

9.5 Termination for Default.

9.5.1 In addition to the rights reserved in the contract, the State may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

9.5.2 Upon termination under this paragraph, all goods, materials, documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State on demand.

9.5.3 The State may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Contractor.

9.6 Continuation of Performance Through Termination. The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

10. Contract Claims

All contract claims or controversies under this Contract shall be resolved according to A.R.S. Title 41, Chapter 23, Article 9, and rules adopted thereunder.

11. Arbitration. The parties to this Contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. § 12-1518, except as may be required by other applicable statutes (Title 41).

12. Comments Welcome

The State Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: State Procurement Administrator, State Procurement Office, 100 North 15th Avenue, Suite 104, Phoenix, Arizona, 85007.

SPECIAL TERMS AND CONDITIONS

A. CONTRACT INTERPRETATION

1. No Guaranteed Quantities

Arizona Department of Health Services (ADHS) does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this Contract.

2. Applicable Requirements

The Contractor and its Subcontractors shall comply with all Federal, State, and local laws, rules, regulations, standards and executive orders governing performance of duties under this Contract, including documents incorporated by reference, without limitation to those designated within this Contract. The Contractor and its Subcontractors shall comply with all applicable Arizona Health Care Cost Containment System (AHCCCS) Rules, policies and procedures relating to the audit of Contractor's records, medical audit protocols, any inspection of Contractor's facilities, and the surveys of Members, providers and reviews.

3. Contract Term

The Contract Award Date shall be the date the State Procurement Officer executes the Offer and Acceptance. Performance to Members shall commence on October 1, 2008 (Contract Effective Date) unless a later date is specified in the Offer and Acceptance award notice. The Contract term shall begin with the Contract Effective Date and shall continue for a period of two (2) years thereafter, unless terminated or extended.

4. Contract Extension

For the purpose of executing a Contract extension, the anniversary date for extension shall be determined based upon the Contract Effective Date in accordance with the "Contract Term" section of these Special Terms and Conditions. By mutual written Contract Amendment, any resultant Contract may be extended for supplemental periods of up to a maximum of twenty-four (24) months, for a time period not to exceed four (4) years.

The four (4) year period shall start on the Contract Effective Date and shall end four (4) years later.

5. Contract Type

Fixed Price

6. Price Increases or Decreases

ADHS may review a fully documented request for price increase only after the Contract has been in effect for twelve (12) months. ADHS shall determine whether the requested price increase or an alternate option is in the best interest of the State.

Price reductions may be submitted to ADHS for consideration at any time during the Contract period. ADHS at its own discretion may accept a price reduction.

7. Capitation Rates

On an annual basis, or as determined necessary by ADHS, the Title XIX and Title XXI capitation rates, including all components (i.e., Covered Services, Administrative Costs and Profit/Risk/Contingencies) as well as the overall reimbursement structure will be updated or re-based in an actuarially sound manner, consistent with CMS requirements.

8. Computation of Time

Unless a provision of this Contract or document incorporated by reference explicitly states otherwise, periods of time referred to in this Contract shall be computed as follows:

A. The period of time shall not include the day of the act, event or default from which the designated period of time begins to run.

B. The period of time shall include each day after the day of the act, event or default from which the designated period of time begins to run.

C. If the period of time prescribed or allowed is less than eleven (11) days, the period of time shall not include intermediate Saturdays, Sundays and legal holidays.

D. If the period of time prescribed or allowed is eleven (11) days or more, the period of time shall include intermediate Saturdays, Sundays and legal holidays.

E. If the last day of the period of time prescribed or allowed is not a Saturday, Sunday or legal holiday, the period of time shall include the last day of the period of time.

F. If the last day of the period of time prescribed or allowed is a Saturday, Sunday or legal holiday, the period of time shall extend until the end of the next day that is not a Saturday, Sunday or legal holiday.

G. The preceding notwithstanding, for all Arizona Procurement Code actions "days" shall be computed in accordance with A.R.S. §1-243.

B. CONTRACT ADMINISTRATION AND OPERATION

1. Legal Entity Requirement

The Contractor shall be separately incorporated or a separate legal entity from a parent, subsidiary or other affiliated company or corporation for the purpose of conducting business as a Contractor with ADHS.

2. Conflict of Interest

The Contractor shall not undertake any work that represents a potential or existing conflict of interest, or which is not in the best interest of ADHS or the State, without prior written approval by ADHS. The Contractor shall fully and completely disclose to ADHS a potential or existing conflict of interest.

3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Contractor warrants that it is familiar with the requirements of HIPAA and HIPAA's accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. The Contractor warrants that it will cooperate with ADHS in the course of performance of this Contract so that both ADHS and the Contractor will be in compliance

with HIPAA, including cooperation and coordination with the ADHS Privacy Officer and other compliance officials required by HIPAA and its regulations. The Contractor shall sign any documents that are reasonably necessary to keep ADHS and the Contractor in compliance with HIPAA, including, but not limited to, the Business Associate Agreement in Exhibit D.

If requested by ADHS, the Contractor agrees to sign the "Arizona Department of Health Services Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as Protected Health Information (PHI) and all other confidential or sensitive information as defined in policy. In addition, if requested, the Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADHS HIPAA Compliance Officer.

4. Offshore Performance of Work Prohibited

Due to security and identity protection concerns, direct services under this Contract shall be performed within the borders of the US. Any services that are described in the specifications or Scope of Work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the US. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the Contract. This provision applies to work performed by Subcontractors at all tiers.

5. Federal Immigration and Nationality Act

By entering into the Contract, the Contractor warrants compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Contractor shall obtain statements from its Subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in

effect through the term of the Contract. The Contractor and its Subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the US Department of Labor's Immigration and Control Act, for all employees performing work under the Contract. I-9 forms are available for download at USCIS.GOV.

The State may request verification of compliance for any Contractor or Subcontractor performing work under the Contract. Should the State suspect or find that the Contractor or any of its Subcontractors are not in compliance, the State may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.

6. IT 508 Compliance

Unless specifically authorized in the Contract, any electronic or IT offered to the State of Arizona under this solicitation shall comply with A.R.S. §§41-2531 and 2532 and Section 508 of the Rehabilitation Act of 1973, which requires that employees and members of the public shall have access to and use of IT that is comparable to the access and use by employees and members of the public who are not individuals with disabilities.

7. Records

In addition to the “Records” section of the Uniform Terms and Conditions, the following shall apply:

The Contractor shall maintain all forms, records, reports and working papers used in the preparation of reports, files, correspondence, financial statements, records relating to Quality of Care (QOC), medical records, prescription files, statistical information and other records specified by ADHS for purposes of audit and program management. The Contractor shall comply with all specifications for record keeping established by ADHS and Federal and State law. All books and records shall be maintained to the extent and in such detail as shall properly reflect each service provided and all net costs, direct and indirect, of labor, materials, equipment, supplies and services, and other costs and expenses of whatever nature for which payment is made to the Contractor.

The Contractor shall also require its independent auditor of financial statements to maintain all working papers related to an audit for a minimum of five (5) years after the date of the financial statement.

The Contractor shall retain medical records in compliance with A.R.S. §§12-2291 and 2297, which requires, among other things, that children's medical records be retained for at least three (3) years after the child's eighteenth (18th) birthday or for at least six (6) years after the last date the child received medical or health care services from the Provider, whichever date occurs later.

The Contractor shall preserve and make available all records for a period of six (6) years from the date of final payment under this Contract except in the following cases:

A. If this Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of six (6) years from the date of any such termination.

B. Records that relate to disputes, litigation, or the settlement of claims arising out of the performance of this Contract, or costs and expenses of this Contract to which exception has been taken by the State, shall be retained by the Contractor until such disputes, litigation, claims, or exceptions have been disposed of, or as required by applicable law, whichever is longer.

8. Audits

In addition to the Audit section of the Uniform Terms and Conditions, the following shall apply:

Audits may be conducted periodically to determine the Contractor's and Subcontractors' compliance with Federal and State codes, rules, regulations and requirements. The Contractor shall submit data, reports and information for audits upon request from ADHS. These audits include, but are not limited to, the following:

A. Auditor General Audits. Contractor and its Subcontractors shall comply with and participate as required in the Performance Audit and other audits conducted by the Arizona Auditor 0General.

B. Other Federal and State Audits. Contractor and its Subcontractors shall comply with and participate as required in other Federal and State audits, including the audit of an inpatient facility.

9. Inspections

At any time during the term of this Contract, the Contractor and its Subcontractors shall fully cooperate with inspections by ADHS, AHCCCS, the US Department of Health and Human Services (including the Center for Medicare and Medicaid Services (CMS)) the Comptroller General, the US Office of Civil Rights (OCR), or any authorized representative of the Federal or State governments. The Contractor and its Subcontractors shall allow the authorized representative of the Federal and State government:

A. access to the Contractor's and Subcontractors' staff and Members;

B. access to books and records related to the performance of the Contract or Subcontracts for inspection, audit and reproduction. This shall include allowing ADHS to inspect the records of any employee who works on the Contract to ensure that the Contractor is in compliance with all laws and regulations; and

C. on-site inspection, or other means, for the purpose of evaluating the quality, appropriateness, timeliness, and safety of services performed under this Contract. This inspection shall be conducted at reasonable times unless the situation warrants otherwise.

10. Requests for Information

ADHS may request financial or other information from the Contractor. Upon receipt of a request for information, the Contractor shall provide complete and accurate information no later than thirty (30) days after the receipt of the request unless otherwise specified by ADHS. The Contractor shall provide all information requested by ADHS on a timely basis to facilitate ADHS obligations and functions.

11. Intellectual Property

For any intellectual property used in the performance of the Contract that is retained and not transferred by the Contractor pursuant to the Uniform

Terms and Conditions, section 3.8, "Ownership of Intellectual Property," Contractor shall be deemed to have provided ADHS and ADHS's designees with a non-exclusive license or similar permission to use such property for nine (9) years from the date the ADHS Procurement Officer executes the Acceptance of Offer. Contractor shall, upon request from ADHS and in a timely manner, take any and all steps that may be necessary to formalize such license or permission. The provisions of this section shall extend beyond Contract termination. It is the intention of the parties that this section shall be completely sufficient to provide ADHS and ADHS's designees with such a license.

12. Transition

When the Contract Term ends or in the event the Contract is terminated with or without cause, the Contractor, whenever determined appropriate by ADHS, shall assist ADHS in the transition of services to other Contractors or the State. Such assistance and coordination shall include but not be limited to, the forwarding of Contract works, electronic files and other records as may be necessary and to assure the smoothest possible transition and continuity of services. The cost of reproducing and forwarding such records and other materials shall be borne by the Contractor. The Contractor must make provisions for continuing all performance under this Contract, to include management/administrative services until the transition of services is complete and all other requirements of this Contract are satisfied.

C. COSTS AND PAYMENTS

1. Payments

In addition to the Payments section of the Uniform Terms and Conditions, the following shall apply:

ADHS shall pay the Contractor in accordance with section "G.2 Contractor's Payments" of the Financial Management and Practices section, subject to the availability of funds and provided that the Contractor's performance is in compliance with this Contract. Payments shall be in compliance with A.R.S. Title 35, Public Finance. ADHS reserves the option to make payments to the Contractor by wire or NACHA transfer and will provide Contractor at least thirty (30) days notice prior to the effective date of any change. When payments are made by

electronic funds transfer, ADHS shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. A payment error discovered by ADHS shall be subject to adjustment or repayment by the Contractor, by making a corresponding decrease in a current Contractor's payment or by making an additional payment to the Contractor. The Contractor shall not assign any payment due by ADHS. This section shall not prohibit ADHS, at its sole discretion, from making payment to a fiscal agent hired by the Contractor or the State.

2. Availability of Funds

ADHS shall not be liable for any purchases or subcontracts entered into by the Contractor or any subcontracted provider in anticipation of funding.

3. Certification of Cost and Price Data

The Contractor shall submit cost and or pricing data to ADHS, as specified by ADHS, in accordance with Arizona Revised Statutes, Title 41, Chapter 23, Articles 3 and 7, and related Arizona Administrative Code (A.A.C.) rules. By signing the Offer and Contract Award form, a Contract Change Order, a Contract Amendment or other official form, the Contractor is certifying that, to the best of the Contractor's knowledge and belief, any cost or pricing data submitted is accurate, complete and current as of the date submitted or other mutually agreed upon date. Furthermore, the Contractor's payment may be adjusted, to exclude any significant amounts by which the ADHS finds the Contractor-furnished cost or pricing data was inaccurate, incomplete or not current as of the date of certification. Such adjustment by the ADHS may include the amount of the defect plus overhead and profit or fees. The cost and pricing data shall be submitted in accordance with A.A.C. R2-7-701 and be sufficiently detailed, accurate, complete and current to ADHS's satisfaction to support and provide the basis for the Contractor's payment provided for in this Contract. The ADHS may make a preliminary finding regarding the suitability of Contractor submitted cost or pricing data and upon final determination by the ADHS, make an adjustment to any payments paid by the ADHS.

D. CONTRACT CHANGES

1. Changes within the General Scope of the Contract

A. ADHS may, at any time, by written notice to Contractor, make changes within the general scope of this Contract. If any change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this Contract, the Contractor may assert its right to an adjustment in compensation paid under this Contract as described in the Price Increases and Decreases section of these Special Terms and Conditions. Contractor shall assert its right to such adjustment within thirty (30) days from the date of receipt of the change notice. Any dispute or disagreement arising from the notice shall be treated as a Contract Claim and shall be settled in accordance with the Contract Claim Dispute Process in this Contract.

B. When ADHS issues an Amendment to modify the Contract, and the Contractor does not assert a right to an adjustment in Contract compensation and/or other dispute or disagreement with the ADHS notice to Contractor, the provisions of the Amendment shall be deemed to have been accepted sixty (60) days after the date of mailing by ADHS, even if Contractor has not signed the Amendment. If the Contractor refuses to sign the Amendment, ADHS may exercise its remedies under this Contract.

2. Merger, Reorganization and Change in Ownership

The Contractor shall obtain prior approval of ADHS and sign a written Contract Amendment for any merger, reorganization or change in ownership of the Contractor, or of a subcontracted Provider that is related or affiliated with the Contractor. The Contractor shall submit a detailed merger, reorganization and/or transition plan to ADHS for review and include strategies to ensure uninterrupted services to Members, evaluate the new entity's ability to support the provider network, ensure that services to Members are not diminished, and that major components of the organization and programs are not adversely affected by the merger, reorganization, or change in ownership.

3. Changes to Documents Incorporated by Reference

ADHS will notify the Contractor when changes are made to a document incorporated by reference that ADHS authored. Changes to any of the documents incorporated by reference do not require a written Contract Amendment.

E. DOCUMENTS INCORPORATED BY REFERENCE

1. Documents Incorporated by Reference

The Contractor shall perform the Contract in accordance with documents incorporated by reference, listed in this section or any other section of the Contract. The following documents, and any subsequent amendments, modifications, and supplements adopted by or affecting ADHS or AHCCCS during the Contract period, are incorporated herein by reference and made a part of this Contract:

A. AHCCCS guidelines, policies and manuals http://www.ahcccs.state.az.us/Publications/GuidesManuals/ or http://www.azahcccs.gov/HPlans&Providers/;

B. AHCCCS Medical Policy Manual (AMPM) http://www.ahcccs.state.az.us/Regulations/OSPpolicy/;

C. AHCCCS Contractor's Operations Manual (ACOM) http://www.ahcccs.state.az.us/Publications/GuidesManuals/ACOM/ACOM.pdf;

D. AHCCCS Technical Interface Guidelines http://www.ahcccs.state.az.us/Publications/GuidesManuals/TIG/preface/prefcont.asp;

E. AHCCCS Encounter Manual, AHCCCS Encounter Companion Document, and AHCCCS Encounter Reporting User's Manual http://www.ahcccs.state.az.us/Publications/GuidesManuals/EncounterManual/default.asp;

F. Transactions and Code Sets http://www.ahcccs.state.az.us/HIPAA/Documents/;

G. AHCCCS Grievance System Reporting Guide http://www.ahcccs.state.az.us/PlansProviders/Reporting/GrievanceGuide/GrievanceSystemReportingGuide.pdf;

H. ADHS/CRSA Guidelines, Manuals and Policies http://www.azdhs.gov/phs/ocshcn/crs/crs_az.htm;

I. CRS Contractors Policy and Procedure Manual http://www.azdhs.gov/phs/ocshcn/crs/crs_policy_az.htm;

J. ADHS/OCSHCN/CRSA Policy and Procedure Manual http://www.azdhs.gov/phs/ocshcn/crs/crsa_policy_procedures.htm;

K. ADHS/CRS Intergovernmental Agreements and Amendments http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

L. Office of Program Support Operations and Procedures Manual http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

M. Fraud and Abuse Unit Operations and Procedures Manual http://www.azdhs.gov/bhs/fau.pdf;

N. CRS Clinical Practice Guidelines Manual http://www.azdhs.gov/phs/ocshcn/crs/crsa_clinical_practice_guidelines.htm;

O. CRS Member Handbook http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/english-handbook020107.pdf (English), http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/spanish-handbook020107.pdf (Spanish);

P. Formulary http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/crs_formulary_2_12_08.pdf';

Q. Cultural Competency Review and Plan http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

R. Provider Network Development and Management Plan http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm:

S. Quality Management Plan (QMP) http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm:

T. Non-Utilization PIP Medical Record Review Summary http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm:

U. Transition PIP Remeasurement Report
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

V. Family Satisfaction Survey
http://www.azdhs.gov/phs/ocshcn/pdfs_files/family-satisfaction-survey-2007.pdf;

W. DME Survey
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

X. Quality Management (QM) Tracking Report Examples
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

Y. MM/UM Tracking Report Examples
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

Z. Financial Reporting Guide
(Attachment within ADHS/CRS AHCCCS Contract);

AA. Financial Statement Reporting Template
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

BB. Adult Cystic Fibrosis Reporting Template
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

CC. CRS File Layout Specification Manual (drafting);
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

DD. Map of CRS Member Locations
http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm;

EE. Office of Grievance and Appeals Database Manual
http://www.azdhs.gov/bhs/scanned/ogadbmanual.pdf;

FF. AHCCCS State Plans with Center for Medicare and Medicaid Services (CMS):
http://www.azahcccs.gov/Publications/PlansWaivers/1115Waivers/default.asp,
http://azahcccs.gov/Publications/PlansWaivers/Plans/Kidscare/CurrentApprovedKidsCareStatePlan_2002/2002_kidscare_cov_pg.asp; and

GG. Joint Principles of the Patient Centered Medical Home http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm.

2. Compliance with Applicable Laws

The Contractor shall comply with all applicable Arizona and Federal laws required by this Contract including, at a minimum, the following:

A. Balanced Budget Act http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr438_05.html;

B. Medicare Modernization Act http://www.azdhs.gov/bhs/mma/mma.htm;

C. Deficit Reduction Act http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr435_05.html;

D. Arizona Administrative Code Title 2, Chapter 19 Administrative Hearing rules http://www.azsos.gov/public_services/Title_02/2-19.htm;

E. Arizona Administrative Code, Title 9, Chapter 22 AHCCCS rules for the Title XIX acute program. http://www.azsos.gov/public_services/Title_09/9-22.htm;

F. Arizona Administrative Code, Title 9, Chapter 28 AHCCCS rules for the Title XIX DDD ALTCS Program http://www.azsos.gov/public_services/Title_09/9-28.htm;

G. Arizona Administrative Code, Title 9, Chapter 31 AHCCCS rules for the Title XXI program http://www.azsos.gov/public_services/Title_09/9-31.htm;

H. Arizona Administrative Code Title 9, Chapter 34 AHCCCS rules for the Grievance System http://www.azsos.gov/public_services/Title_09/9-34.htm;

I. Arizona Administrative Code Title 9, Chapter 7, Department of Health Services, Children's Rehabilitation Services rules http://www.azsos.gov/public_services/Title_09/9-07.htm;

J. A.R.S. §36-261: Powers and duties; expenditure Limitations http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00261.htm&Title=36&DocType=ARS;

K. A.R.S. §36-261.01: Joint bids; lawful trade practices http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00261-01.htm&Title=36&DocType=ARS;

L. A.R.S. §36-262: Central statewide information and referral service for chronically ill or physically disabled children; definition http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00262.htm&Title=36&DocType=ARS;

M. A.R.S. §36-263: Eligibility for Children's Rehabilitative Services http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00263.htm&Title=36&DocType=ARS;

N. A.R.S. §36-264: Coordination of Benefits; third party payments; definition http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00264.htm&Title=36&DocType=ARS; and

O. A.R.S. §36-265: Children's Rehabilitative Services State Parent Action Council (SPAC); membership; duties; regional Parent Action Councils (PACs); program termination http://www.azleg.state.az.us/FormaftDocument.asp?inDoc=/ars/36/00265.htm&Title=36&DocType=ARS.

F. RISKS AND LIABILITY

1. Indemnification

The Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising

out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the Contractor from and against any and all claims. It is agreed that the Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission or the University of the State of Arizona.

2. Insurance

The Contractor and Subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract are satisfied, insurance against claims for injury to persons or damage to property that may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or Subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or Subcontractors, and the Contractor is free to purchase additional insurance.

A. <u>MINIMUM SCOPE AND LIMITS OF INSURANCE:</u> The Contractor shall provide coverage with limits of liability not less than those stated below.

(1). Commercial General Liability – Occurrence Form
Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

- General Aggregate..... $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Blanket Contractual Liability – Written and Oral$1,000,000
- Fire Legal Liability .....$ 50,000
- Each Occurrence $1,000,000

(a). The policy shall be endorsed to include coverage for sexual abuse and molestation.

(b). The policy shall be endorsed to include the following additional insured language: *"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".*

(c). The policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

(2). Automobile Liability
Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of this Contract.

- Combined Single Limit (CSL).....$1,000,000

(a). The policy shall be endorsed to include the following additional insured language: *"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving*

automobiles owned, leased, hired or borrowed by the Contractor".

(3). Worker's Compensation and Employers' Liability

- Workers' Compensation ..... Statutory

Employers' Liability
- Each Accident .....$ 500,000
- Disease – Each Employee .....$ 500,000
- Disease – Policy Limit $1,000,000

(a). The policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

(b). This requirement shall not apply to: Separately, EACH Contractor or Subcontractor exempt under A.R.S. 23-901, AND when such contractor or Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

(4). Professional Liability (Errors and Omissions Liability)

- Each Claim $1,000,000
- Annual Aggregate $2,000,000

(a). In the event that the professional liability insurance required by this Contract is written on a claims-made basis, the Contractor warrants that any retroactive date under the policy shall precede the Contract Award date; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.

(b). The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. ADDITIONAL INSURANCE REQUIREMENTS: The policies shall include, or be endorsed to include, the following provisions:

(1). The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this Contract.

(2). The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.

(3). Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this Contract.

C. NOTICE OF CANCELLATION: Each insurance policy required by the insurance provisions of this Contract shall provide the required coverage and shall not be suspended, voided, canceled, or reduced in coverage or in limits except after thirty (30) days prior written notice has been given to the State of Arizona. Such notice shall be sent directly to ADHS, Office of Procurement, 1740 W. Adams, Room 303, Phoenix, AZ 85007, and shall be sent by certified mail, return receipt requested.

D. ACCEPTABILITY OF INSURERS: Insurance is to be placed with duly licensed or approved non-admitted insurers in the State of Arizona with an “A.M. Best” rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. VERIFICATION OF COVERAGE: The Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and endorsements are to be received and approved by the State of Arizona before work commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this Contract shall be sent directly to ADHS, Office of Procurement, 1740 W. Adams, Room 303, Phoenix, AZ 85007. The State of Arizona project/contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time**. DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT SECTION.**

F. SUBCONTRACTORS: The Contractor's certificate(s) shall include all Subcontractors as insureds under its policies **or** the Contractor shall furnish to the State of Arizona separate certificates and endorsements for each Subcontractor. All coverages for Subcontractors shall be subject to the minimum requirements identified above.

G. APPROVAL: Any modification or variation from the insurance requirements in this Contract shall be made by the Department of Administration, Risk Management Section, whose decision shall be final. Such action will not require a formal Contract Amendment, but may be made by administrative action.

H. EXCEPTIONS: In the event the Contractor or sub-contractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or Sub-contractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

3. Warranties

Contractor, by execution of this Contract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in

this Contract and that all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with standards required by Federal or State law, rules and regulations.

4. Performance Bond

The Contractor shall be required to furnish an irrevocable security in the amount equal to eighty percent (80%) of the total capitation payment expected to be paid to the Contractor in the first month of the contract year, or as determined by ADHS, payable to the State of Arizona, binding the Contractor to provide faithful performance of the Contract. This requirement must be satisfied by the Contractor no later than thirty (30) days after notification by ADHS of the amount required. Thereafter, ADHS will review the adequacy of the performance bond on a monthly basis to determine if the performance bond must be increased. The Contractor shall have thirty (30) days following notification by ADHS to increase the amount of the performance bond. The performance bond amount that must be maintained after the Contract term shall be sufficient to cover all outstanding liabilities and will be determined by ADHS. The Contractor may not change the amount of the performance bond without prior written approval from ADHS.

The Contractor shall obtain and maintain a performance bond, rated at least A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in Arizona issued by the Director of the Department of Insurance pursuant to A.R.S. Title 20, Chapter 2, Article 1, and in a form prescribed by A.A.C. Title 2, Chapter 7, Article 505.

Performance security shall be in the form of a performance bond, certified check or cashier's check. All performance bonds must be executed on forms substantially equivalent to the form included with this Solicitation as Exhibit H. This security must be in the possession of the State within ten (10) calendar days from receipt of Contract Award date. If the Contractor fails to execute the security document, as required, the Contractor may be found in default and Contract terminated by the State. In case of default, the State reserves all rights to recover as provided by law.

The Contractor agrees that if it is declared to be in default of any material term of this Contract, ADHS shall, in addition to any other remedies it may have under this Contract, obtain payment under the performance bond for the following:

A. paying damages sustained by subcontracted providers, non-contracting providers, and non-providers as a result of a breach of Contractor's obligations under this Contract;

B. reimbursing ADHS for any payments made by ADHS on behalf of the Contractor;

C. reimbursing ADHS for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this Contract, including, expenses incurred after termination of this Contract by ADHS; and

D. making any payments or expenditures deemed necessary to ADHS, in its sole discretion, incurred by ADHS in the direct operation of the Contractor pursuant to the terms of this Contract and to reimburse ADHS or any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor by ADHS pursuant to the terms of this Contract.

The Contractor shall reimburse ADHS for expenses exceeding the performance bond amount.

G. CONTRACT TERMINATION

1. Voidability of Contract

This Contract is voidable and subject to immediate termination by ADHS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the US Code, or upon assignment or delegation of the Contract without the prior written approval of ADHS.

2. Notice to Cure

ADHS may issue a Notice to Cure and upon receipt of the Notice, the Contractor shall provide a satisfactory response to ADHS within the time-frame specified by the Notice. Failure on the part of the Contractor to adequately address all issues of concern may result in ADHS implementing any single or combination of the remedies identified in the Administration section "E.9 Corrective Actions, Sanctions, Notices to Cure and Contractor Claim Disputes" of the Scope of Work, the Performance

Bond section of the Special Terms and Conditions, or the following remedies:

A. cancel the Contract for default and send a Notice of Termination;

B. reserve all rights or claims to damage for breach of any covenant of the Contract, and/or

C. perform any test or analysis for compliance with the specifications of the Contract. If the result of any test confirms a material non-compliance with the specifications, any reasonable expense of testing shall be borne by the Contractor.

3. ADHS Rights Following Contract Termination

If the Contract is terminated in accordance with the Contract Termination section of the Uniform Terms and Conditions, ADHS reserves the right to purchase materials or to complete the required work in accordance with the Arizona Procurement Code. ADHS may recover any reasonable excess costs resulting from these actions from the Contractor by:

A. deduction from an unpaid balance;

B. collection against the bid and/or performance bond or performance bond substitute; and

C. any combination of the above or any other remedies as provided by law or equity, whether or not specified in this Contract.

4. Contractor Obligations

In the event the Contract or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist ADHS in the transition of its Members to another Contractor at its own expense. In addition, ADHS reserves the right to extend the term of the Contract on a month-to-month basis to assist in any transition of Members. The Contractor shall:

A. make provisions for continuing all management and administrative services and the provision of direct services to Members until the transition of all Members is completed and all other requirements of this Contract are satisfied;

B. designate a person with appropriate training to act as a transition coordinator. The transition coordinator shall interact closely with ADHS and the staff from the new contractor to ensure a safe and orderly transition;

C. upon ADHS' request, submit for approval a detailed plan for the transition of its Members, including the name of the transition coordinator;

D. provide all reports set forth in this Contract and necessary for the transition process. This includes providing to ADHS, until ADHS is satisfied that the Contractor has paid all such obligations: 1) a monthly claims aging report by provider/creditor including Incurred But Not Reported (IBNR) amounts, 2) a monthly summary of cash disbursement; and 3) copies of all bank statements received by the Contractor. These reports shall be due on the fifth (5th) day of each succeeding month for the prior month;

E. notify Subcontractors and Members of the Contract termination as directed by ADHS;

F. complete payment of all outstanding obligations for Covered Services rendered to Members. The Contractor shall cover continuation of services to Enrollees for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge;

G. cooperate with a successor contractor during the transition period including, at minimum, sharing and transferring Member information and records. ADHS will notify the Contractor with specific instructions and required actions at the time of transfer;

H. return any funds advanced to the Contractor for coverage of Members for periods after the date of termination to ADHS within thirty (30) days of termination of the Contract; and

I. supply all information necessary for reimbursement of outstanding claims.

5. Impact on Indemnification

In the event of expiration, termination or suspension of the Contract by ADHS, the expiration, termination or suspension shall not affect the obligation of the Contractor to indemnify ADHS for any claim by any third party against the State or ADHS arising from the Contractor's performance of this Contract and for which the Contractor would otherwise be liable under this Contract.

6. Additional Obligations

In addition to the requirements stated above and in the Uniform Terms and Conditions, Paragraphs on Termination for Convenience and Termination for Default, the Contractor shall comply with the following provisions:

A. The Contractor shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management Subcontractors, in writing, to stop all work as of the effective date of the Notice of Termination.

B. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this Contract and in accordance with a written plan approved by ADHS for the orderly transition of Members to another Contractor.

C. Unless otherwise directed by ADHS, the Contractor shall direct subcontracted providers to continue to provide services consistent with the Member's Service and Treatment Plans.

7. Disputes

Any dispute by the Contractor with respect to termination or suspension of this Contract by ADHS shall be exclusively governed by the Resolution of Contract Claim provisions of this Contract.

8. Payment

The Contractor shall be paid the Contract price for all services and items completed prior to the effective date of the Notice of Termination.

H. CONTRACT CLAIMS DISPUTE PROCESSING

1. Resolution of Contract Claims

A Contract Claim is any claim or controversy, other than a Provider Claim Dispute, arising out of the terms of this Contract. Except for Provider Claim Disputes, all Contract Claims or controversies under this Contract shall be resolved according to Uniform Terms and Conditions, Paragraph 10. Contract Claims. Prior to filing a Contract Claim, the Contractor may resolve the dispute informally with ADHS; however, nothing in the informal dispute resolution process shall waive applicable deadlines within which to file a Contract Claim.

2. Claim Disputes

A Contractor Claim Dispute is the Contractor's dispute of a Contract claim, other than a claim for payment for delivery of Covered Services, denial of claim, or imposition of a sanction by ADHS. All Contractor Claim Disputes with ADHS shall be resolved in accordance with the process set forth in both the ADHS Policy on Contractor Claim Disputes and other documents incorporated herein by reference.

3. Payment Obligations

The Contractor shall pay and perform all of its obligations and liabilities when and as due, provided, however, that if and to the extent there exists a bona fide dispute with any party to whom the Contractor may be obligated, the Contractor may contest any obligation so disputed until final determination by a court of competent jurisdiction; provided, however, that the Contractor shall not permit any judgment against it or any levy, attachment, or process against its property, the entry of any order or judgment of receivership, trusteeship, or conservatorship or the entry of any order to relief or similar order under laws pertaining to bankruptcy, reorganization, or insolvency, in any of the foregoing cases to remain undischarged, or unstayed by good and sufficient bond, for more than fifteen (15) days. Members may not be held liable for payment in the event of the Contractor's insolvency, ADHS' failure to pay the Contractor, or ADHS' or the Contractor's failure to pay a Provider.

I. USE OF FUNDS FOR LOBBYING

The Contractor shall not use funds paid to the Contractor by ADHS, or interest earned, for the purpose of influencing or attempting to influence any officer or employee of any State or Federal agency; or any member of, or employee of a member of, the US Congress or the Arizona State Legislature 1) in which it asserts authority to represent ADHS or advocate the official position of ADHS in any matter before a State or Federal agency; or any member of, or employee of a member of, the US Congress or the Arizona State Legislature; or 2) in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement.

J. ANTI-KICKBACK

The Contractor or any director, officer, agent, employee or volunteer of the Contractor shall not request nor receive any payment or other thing of value either directly or indirectly, from or for the account of any Subcontractor (except such performance as may be required of a Subcontractor under the terms of its Subcontract) as consideration for or to induce the Contractor to enter into a subcontract with the Subcontractor or any referrals of Enrolled persons to the Subcontractor for the provision of Covered Services.

The Contractor certifies that it has not engaged in conduct that would violate the Medicare Anti-kickback statute (42 U.S.C. 1320a-7b) or the “Stark I” and “Stark II” laws governing related-entity referrals (PL101-239 and PL 101-432) and compensation.

K. TRANSITIONS AND IMPLEMENTATION

1. Transition Period

During the transition period, the Contractor shall implement the terms of this Contract and collaborate with ADHS to effectuate the seamless transition between the existing contract and this Contract in order to prevent interruption of services and promote continuity of care to Members. Upon Contract Award, ADHS, the existing contractor and the new Contractor, if different, shall immediately collaborate to:

A. Define project management and reporting standards,

B. Establish communication protocols between the Contractor, ADHS and existing contractors and Providers,

C. Establish an implementation plan that includes, at a minimum, the schedule for key activities and milestones identified in Exhibit F, and this section K.2. Implementation Period and Plan of the Special Terms and Conditions.

D. Define expectations for content and format of Contract deliverables.

2. Implementation Period and Plan

The Contractor shall develop a comprehensive written Implementation Plan to monitor progress throughout the transition and implementation periods. The Contractor shall submit a revised Implementation Plan (based on ADHS feedback for the proposed Implementation Plan) to ADHS for final review and approval no later than fourteen (14) days from the Notice of Contract Award. The Contractor, as required by ADHS, shall provide ADHS with verbal and written Implementation Plan updates and shall cooperate and communicate with ADHS to resolve transition and implementation issues to ADHS' satisfaction. The Contractor shall include in the Implementation Plan a detailed description of its implementation methods, staff assigned to be accountable for completing tasks and timetables, including, at a minimum, the following components:

A. human resource and staffing plan;

B. facilities acquisition and installation plans, as applicable;

C. a plan for providing continuous Member Services;

D. telephone systems plan;

E. data systems plan, including hardware and equipment acquisition and installation, operating system and software installation, and file installation;

F. system readiness testing and acceptance testing plan and a data conversion plan to include, at a minimum, intake, eligibility, demographics, Encounters, and other file data;

G. a network development plan, including analysis and plans to effect a smooth transition;

H. Covered Services transition and continuity of care;

I. pending Grievance and Appeal transition;

J. security, business continuity, disaster recovery, and contingency plan;

K. communication plan that includes a plan to communicate with Members, family members, and other stakeholders regarding the transition;

L. website;

M. communication and transition plan with existing Providers;

N. plan to meet other administrative start-up requirements;

O. transfer of electronic data and records;

P. transfer of paper copy records;

Q. transfer of property, including real property, deeds of purchase, leases, staff, and equipment, as applicable;

R. budget plan for transition expenses, including applicable Contractor travel, personnel;

S. taxes, and anticipated service development costs prior to the Contract Start Date;

T. Member Handbook and Provider Manual completion;

U. claims and eligibility interface development;

V. compliance plan;

W. financial reporting plan;

X. pricing of Encounters;

Y. orientation and training plan for staff and provider network; and

Z. post-implementation deliverables.

3. Personnel

No later than two (2) weeks prior to the Contract Effective Date, the Contractor shall complete hiring of its Key Personnel or approved interim Key Personnel. The Contractor shall submit to ADHS the resumes of each Key Personnel position for prior ADHS approval and updated organizational charts. The Contractor shall have sufficient personnel working and operating in Arizona during the transition and implementation periods in order to be fully compliant with the terms of this Contract.

4. Transitioning Members and Operations

When applicable, the Contractor shall transition Members receiving Covered Services so care is not disrupted. The Contractor shall collaborate with existing contractors and providers to develop and implement Member transition plans to preserve continuity of care. At a minimum, the Contractor shall provide service information, emergency telephone numbers and instructions about obtaining additional services to each Member involved in the transition of care.

The Contractor shall transition pending Grievances, Appeals, and Member Service cases as appropriate to assure timely resolution. The Contractor shall have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

5. Operational and Financial Readiness Reviews

Prior and subsequent to the Contract Effective Date, the Contractor shall cooperate with ADHS's Operational and Financial Readiness Reviews to assess the Contractor's readiness and ability to provide Covered Services to Members and to resolve previously identified operational deficiencies. Upon ADHS's request and approval, the Contractor shall develop and implement a CAP in response to deficiencies identified during the Readiness Review. The Contractor shall commence operations only if the

Readiness Review factors and CAP requirements are met to ADHS's satisfaction.

At a minimum, the Contractor shall cooperate with ADHS to review the following areas:

A. network sufficiency and management including reviews of Subcontracts;

B. staffing adequacy;

C. Member Services;

D. Quality Management;

E. Medical Management/Utilization Management (MM/UM);

F. Financial Management;

G. Management Information System processing and testing;

H. transition of Members;

I. routine communications with Members;

J. continuity of care for Members;

K. MSIC operations; and

L. Grievance System requirements.

During the Readiness Review, the Contractor shall provide ADHS with access to staff, documentation and work space as requested by ADHS.

6. Definition of Terms

Definitions are included in the last section of this Contract and incorporated into the Special Terms and Conditions herein. For ease of readability, terms or phrases having a specific or unique meaning within the context of this Solicitation are capitalized to signify that a definition has been provided in the Definitions section. If the definitions in the Definitions section of the Contract are in conflict with definitions in the Uniform Terms

and Conditions or Arizona Procurement Code, the definitions in the Uniform Terms and Conditions or Arizona Procurement Code will take precedence.

7. Pandemic Contractual Performance

In addition to the requirements in the Business Continuity/Recovery Plan and Emergency Response section of the Scope of Work:

A. The State shall require a written plan that illustrates how the Contractor shall perform up to Contractual standards in the event of a pandemic. The State may require a copy of the plan at anytime prior or post award of a Contract. At a minimum, the pandemic performance plan shall include:
   (1). key succession and performance planning if there is a sudden significant decrease in Contractor's workforce;
   (2). alternative methods to ensure there are products in the supply chain;
   (3). an up-to-date list of company contacts and organizational chart.

B. In the event of a pandemic, as declared by the Governor of Arizona, US Government or the World Health Organization, which makes performance of any term under this Contract impossible or impracticable, the State shall have the following rights:
   (1). After the official declaration of a pandemic, the State may temporally void the Contract(s) in whole or specific sections, if the Contractor cannot perform to the standards agreed upon in the initial terms.
   (2). The State shall not incur any liability if a pandemic is declared and emergency procurements are authorized by the Director as per A.R.S. §41-2537 of the Arizona Procurement Code.
   (3). Once the pandemic is officially declared over and/or the Contractor can demonstrate the ability to perform, the State, at is sole discretion, may reinstate the temporarily voided Contract(s).

SCOPE OF WORK
SOLICITATION NO. HP832090

SCOPE OF WORK

A. INTRODUCTION AND BACKGROUND

1. Purpose of the Request for Proposal and Contract Award

In accordance with Article 3, Arizona Revised Statutes (A.R.S.) §§36-261 and 36-262 and Article 13, A.R.S. §§36-797.43 and .44, the purpose of this RFP is for the Arizona Department of Health Services/Children's Rehabilitative Services Administration (ADHS) to contract with a Managed Care Organization (MCO) to become a Children's Rehabilitative Services Organization (CRSO or Contractor) that administers the Children's Rehabilitative Services (CRS) program to eligible Members. The CRS program specializes in administering needed services for individuals with chronic and disabling or potentially disabling health conditions. If necessary, ADHS will contract with multiple contractors to meet the service needs of its Members. To maximize service integration and reduce administrative burden and cost, however, ADHS's goal is to contract with a single contractor.

ADHS is procuring a CRSO that shall arrange for and manage the timely delivery of well-coordinated, multi-specialty, interdisciplinary Covered Services by a network of qualified providers to Members in all regions of the State. Based on the Contractor's experience with and expertise in the delivery and management of publicly funded services for children with special health care needs similar to those treated in the CRS program, the Contractor shall implement proven strategies that ensure Members ready access to effective, person- and Family-Centered, culturally and linguistically appropriate care, delivered in a manner consistent with Practice Guidelines and Best Practices throughout Arizona.

The Contractor shall use data-driven approaches to inform, support and perform key Contract service delivery, managed care and network requirements including multi-specialty, interdisciplinary care, family support services, integrated medical records, timely Service Plan implementation, planning for adulthood, care coordination, network adequacy and medical management/utilization management (MM/UM) and quality management (QM). The Contractor's commitment to Member rights, family involvement and continuous quality improvement shall be evident in all its policies, practices and decision-making. The Contractor's management team shall identify and implement industry-leading tools,

technology, and strategies that improve clinical and administrative outcomes and reduce unnecessary costs.

Currently, the CRS program provides services through four regional provider organizations, each with a hospital (owned or affiliated), clinic and physician support. The Northern Regional Clinic is in Flagstaff; the Western Regional Clinic is in Yuma; the Southern Regional Clinic is in Tucson; and the Central Regional Clinic is in Phoenix. In addition to the four regional clinic sites, services are provided through a variety of Field Clinics operated by the regional contractors.

The Contractor shall transform the current regional system into a single, Statewide, organized, seamless service delivery system and organization. The transformed system will provide Members access (or virtual access) to a Statewide network of multi-specialty providers in a variety of service settings including MSICs, clinic-like settings (e.g., Field Clinics, Virtual Clinics) and community-based pharmacies, therapies, lab and diagnostic services. The effective use of innovative delivery strategies and technology will increase Members' options for choice among providers and enhance the coordination of multi-specialty, interdisciplinary care when indicated.

In partnership with ADHS, the Contractor shall deliver Covered Services in a manner consistent with the CRS mission, philosophy and objectives. The Contractor shall manage care to promote more appropriate utilization of services, minimize the need for emergency care and improve the quality of care (QOC).

The mission of the CRS program is to improve the health and quality of life of children who have certain medical, disabling or potentially disabling conditions by providing Family-Centered medical treatment, rehabilitation and related support services to Members. An individual is eligible for CRS if he or she is a citizen of the United States or a qualified alien, resides in Arizona, is less than twenty-one (21) years of age and is diagnosed with one of the CRS-related conditions.

Although CRS is primarily a children's program, Adult programs for Cystic Fibrosis and Sickle Cell Anemia may also be provided to qualified individuals twenty-one (21) years of age or older. CRS covered conditions are enumerated in Title 9, Chapter 7, Article 2, Section 202 of the Arizona Administrative Code (A.A.C.) and Chapter 5.0 of the Contractor's Policy and Procedure Manual (CPPM), which is hereby incorporated by reference. The rules and CPPM can be located at http://www.azsos.gov/public_services/Title_09/9-07.htm and http://www.azdhs.gov/phs/ocshcn/crs/crs_policy_az.htm respectively.

CRS manages the care for what are often complicated medical conditions. Examples of conditions covered under the CRS program are:

- cerebral palsy,
- club feet,
- dislocated hips,
- cleft palate,
- scoliosis,
- spina bifida,
- cystic fibrosis,
- heart conditions due to congenital deformities,
- metabolic disorders,
- muscle and nerve disorders,
- neurofibromatosis, and
- sickle cell anemia.

2. Overview of Contractor Tasks

The Contractor shall manage and deliver Covered Services Statewide to the Enrolled CRS population as described in this Contract, all documents incorporated by reference, the Solicitation, its Amendments, and the proposal and its Amendments. Specifically, the Contractor shall utilize its experience and expertise to:

A. deliver, through its Subcontractors, Family-Centered, culturally competent, multi-specialty, interdisciplinary healthcare and managed healthcare services including:

(1). Medically Necessary Covered Services, covered family support services, Eligibility assessments and timely enrollment processes;

(2). a process for using a centralized, integrated medical record accessible to the Contractor and service providers consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care;

(3). establishment and implementation of a centralized Service Plan accessible to the Contractor and service providers consistent with Federal and State privacy laws that contain the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation;

(4). development of Transition Plans for Member transition into adulthood;

(5). management of services through:

(a). QM;
(b). MM/UM;
(c). Credentialing of contracted Providers;
(d). Member Services, information and referral;
(e). Grievances, Appeals and Claims Dispute processing;

(6). collaboration with individuals, groups, organizations and agencies charged with the administration, support or delivery of services for children with special health care needs including AHCCCS Health Plans and Program Contractors, their Primary Care Physicians (PCPs) and specialists; and

(7). a continuous quality improvement approach to operations that is based on accurate and complete data collection, monitoring and reports;

B. establish, monitor, and maintain a Statewide Provider network that at a minimum:

(1). provides well-coordinated, Family-Centered, culturally and linguistically appropriate, multi-specialty, interdisciplinary, Covered Services for individuals Enrolled in the CRS program including:

(a). inpatient services,

(b). Emergency Services,
(c). audiology services,
(d). dental and orthodontia services,
(e). diagnostic testing and laboratory services,
(f). home health services,
(g). nursing services,
(h). nutrition services,
(i). physician services,
(j). pharmacy services,
(k). occupational therapy, and
(l). physical therapy;

(2). improves Member access to and choice of qualified network providers that deliver Covered Services consistent with Practice Guidelines and Best Practices;

(3). provides Members convenient and timely appointment access to culturally responsive Medically Necessary Services and/or family support services; and

(4). utilizes innovative strategies and up-to-date technology to create virtual network access for Members;

C. demonstrate administrative competence through:

(1). administration and payment of claims and encounters consistent with performance requirements for accuracy and timeliness;

(2). development and implementation of business continuity, disaster recovery and emergency preparedness; and

(3). meeting or exceeding Contract requirements, including Performance Standards;

D. provide, utilize and enhance information technology (IT), systems, resources, and personnel that:

(1). minimize downtime;

(2). are compatible with ADHS's IT system; and

(3). in accordance with the Governor's Executive Order #2005-25 on Arizona's Health-e Connection Roadmap, cooperate in the development of electronic health information data exchange (EHI) of personal health information between providers, payers and members and the deployment of necessary health IT to facilitate electronic health records in provider offices;

E. operate in a fiscally responsible manner that minimizes unnecessary Administrative Costs including:

(1). implementation of financial management strategies that ensure Administrative Costs do not exceed those proposed; and

(2). remaining financially viable and stable as demonstrated by meeting the specific financial requirements delineated in this Contract;

F. implement the proposed CRS program in a manner that meets Contract requirements by the respective deadlines and Contract Effective Date; and

G. hiring, training and retaining sufficient qualified Key Personnel, Organizational Staff and other employees with the experience and expertise necessary for the administration of this Contract.

B. OVERVIEW OF THE CHILDREN'S REHABILITATIVE SERVICES PROGRAM

1. CRS Organizational Structure

ADHS is responsible for the administration of Arizona's CRS program to Members. The Children's Rehabilitative Services Administration (CRSA) operates within the Office for Children with Special Health Care Needs (OCSHCN) as part of ADHS. The State's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), has a contract with ADHS to serve as a Prepaid Inpatient Health Plan (PIHP) to administer the CRS Program on a carve-out basis for Title XIX and Title XXI Members who meet CRS Eligibility and Enrollment criteria. ADHS also administers the CRS program for Non-Title XIX and Non-Title XXI Children and Adults. ADHS plans to delegate responsibility for certain

CRS services and related activities as described in this Contract (42 C.F.R. 438.230(a)) to a Contractor.

2. CRS Eligible Population and Covered Services

An individual is eligible for CRS if he or she is a citizen of the United States or a qualified alien, resides in Arizona, is less than twenty-one (21) years of age and is diagnosed with one of the medical conditions listed in A.A.C. R9-7-202. Adults who are United States citizens or qualified aliens, reside in Arizona, and have Cystic Fibrosis or Sickle Cell Anemia may also be eligible for CRS. Following successful completion of the enrollment process, financial screening and payment agreement, individuals who are eligible for CRS become Enrolled in the CRS program to receive Medically Necessary Covered Services and support services.

ADHS receives Federal funding from AHCCCS for Title XIX eligible AHCCCS members and for Title XXI eligible AHCCCS members for services for CRS Members. The Arizona legislature appropriates funds for CRS services for Non-Title XIX and Non-Title XXI eligible (State-only) children and Adults meeting medical eligibility and specific income requirements. The Adult programs for Cystic Fibrosis and Sickle Cell Anemia are funded with State-only appropriations.

During the State Fiscal Year (SFY) ending June 30, 2007, there were approximately 23,078 children Enrolled in the CRS program. There were 4,836 children and adults supported with State-only funds. Updated Membership numbers and a map showing Member dispersion throughout the State may be obtained at the following websites: http://www.azdhs.gov/phs/ocshcn/data_statistics.htm and http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm.

CRS covers medical treatment, rehabilitation and family support services (such as advocacy and child life services) collectively enumerated in Chapter 6.0 in the CPPM and A.A.C. Title 9, Chapter 7, Articles 4 and 5. CRS covered conditions are enumerated in Title 9, Chapter 7, Article 2, Section 202 of the A.A.C. and Chapter 5.0 of the CPPM, which is hereby incorporated by reference. The Contractor shall provide for the delivery of Covered Services in accordance with Contract requirements and all documents incorporated by reference.

3. CRS Legislative, Legal and Regulatory Issues

The Contractor agrees to abide by and conform to all requirements of all applicable Arizona and Federal laws and regulations including, but not limited to: A.R.S. §§36-261 through 265; A.R.S. §36-143; A.R.S. §§36-797.41 through 797.44; A.A.C. Title 9, Chapter 7; ADHS Intergovernmental Agreements (IGAs), and Interagency Service Agreements (ISAs) and Amendments; all policy manuals and guides including the AHCCCS Medical Policy Manual, the AHCCCS Contractor Operations Manual, the CRSA Contractor's Policy and Procedures Manual, all Federal and State laws and regulations applicable to the Title XIX and Title XXI programs, and any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. Part 80; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975, as amended, as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990 (ADA); the Balanced Budget Act of 1997 (BBA or Medicaid Managed Care Regulations); the Medicare Prescription Drug Improvement and Modernization Act of 2003; the Deficit Reduction Act of 2005; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations implementing it. In addition, the Contractor shall sign and comply with, and require its Business Associates to sign and comply with the Business Associate Agreement provided in Exhibit D. These laws and regulations are hereby incorporated into this Contract by reference.

In addition to the requirements described in this Contract, there may be legislative issues or directives, regulatory changes, or lawsuits that will have an impact on services delivered by the Contractor on or after the Contract Effective Date. The following is a brief description of the issues known to ADHS at this time:

A. Legislation

The Arizona Legislature annually appropriates monies to ADHS to fund services for Non-Title XIX and Non-Title XXI Members up to a certain percent of the Federal Poverty Level (FPL). This percent may be adjusted each year for new Members in accordance with the appropriation level.

B. Rules

Proposed changes to the rules in A.A.C., Title 9, Chapter 7 governing the CRS program are under consideration. These proposed changes are designed to more accurately reflect eligibility criteria, covered conditions and address service gaps and benefits limits. Once adopted, the revised rules will be incorporated by reference into this Contract.

C. Waiver

The AHCCCS program operates under the authority of an 1115 Waiver. From time-to-time, AHCCCS may seek authority to implement new programs or benefits for Eligible individuals in Arizona. Changes to the authority provided by the 1115 Waiver may affect the management of services delivered to Eligible individuals under this Contract. If significant, the changes will be included through a Contract Amendment.

C. MANAGED CARE AND SERVICE DELIVERY

1. Managing Care

In partnership with ADHS, the Contractor shall apply managed care practices in a manner that results in Members receiving well-coordinated, Medically Necessary, Covered Services that are person- and Family-Centered, timely, culturally responsive, and effective in reducing symptoms stemming from Members' conditions, thus, maximizing functioning and improving Members' quality of life. The Contractor shall be proactive, collaborative and innovative in organizing, operating, and administering a delivery system that meets the needs of Members.

The Contractor shall manage care Statewide for the Enrolled CRS population as described in this Contract and all documents incorporated by reference, Contract and its Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the Managed Care requirements identified in CPPM and this Contract.

If the Contractor obtains approval from ADHS to delegate any required activities, the Contractor shall oversee the Subcontractors or other entities performance of the delegated activities. For all delegated activities, the Contractor shall: 1) obtain a written agreement specifying the delegated activities and reporting responsibilities of the entity, which provides for revocation of the delegation or other remedies (e.g., sanction) for inadequate performance; 2) evaluate the entity's ability to perform the activities prior to delegation; 3) conduct ongoing oversight of the performance and quality of services provided, including a formal annual review and report submitted to ADHS; and 5) written evaluations and corrective action plans (CAPs) as needed.

A. Quality Management

(1). Overview and General Requirements

The Contractor shall work collaboratively with ADHS to effectively implement and continually improve the CRS QM program.

The Contractor and its Subcontractors shall provide high quality medical care to Members, regardless of payer source or eligibility category. The Contractor shall use and disclose medical records and any other health and enrollment information that identifies a particular member for QM purposes in accordance with State and Federal privacy requirements. As directed by ADHS, the Contractor shall conduct the assessment, planning, implementation and evaluation of QM and performance improvement activities that include at least the following (42 C.F.R. 438.240):

- conducting Performance Improvement Projects (PIPs);
- QM monitoring and evaluation activities including assisting ADHS with evaluating the impact and effectiveness of its QM program;
- investigation, analysis, tracking and trending of QOC issues that are not classified as Grievances:
- performance measures, outcome evaluation, and interventions;
- Credentialing, recredentialing and provisional Credentialing processes for providers and organizations compliant with requirements in 42

C.F.R 438.214 for selection and retention of providers and nondiscrimination requirements in 42 C.F.R. 438.206(b)(6); and

- Peer Review.

The Contractor shall conduct QM for the Enrolled CRS population as described in this Contract, including AHCCCS AMPM Chapter 900, and all other documents incorporated by reference, Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall have a sufficient number of qualified personnel to oversee the Contractor's QM and Performance Improvement Activities and to track, review, and investigate QOC issues. The staff shall include Arizona-licensed registered nurses and physicians with expertise in the delivery of services to children with special healthcare needs. The Contractor shall comply with all QM requirements in a timely manner and avoid review and monitoring unlikely to affect service delivery or QOC. The Contractor shall have written policies and procedures that address the following:

(a). Assessment, measurement and improvement of the QOC provided to Members in accordance with:
   i. the QM requirements identified in this Contract;
   ii. the CRS QM Plan;
   iii. the CPPM, Chapter 12.0;
   iv. the AHCCCS QM requirements outlined in the AHCCCS AMPM, Chapter 900) http://www.ahcccs.state.az.us/ Regulations/OSPpolicy/; and
   v. other applicable documents incorporated by reference.

(b). Data collection and analysis. The Contractor shall verify the accuracy and timeliness of reported data, screen the data for completeness, logic and consistency, and collect service information in standardized formats.

(c). Implementation of the annual ADHS QM Plan. The Contractor shall participate in the review of quality improvement findings and shall take action as directed by ADHS to improve the QOC within the CRS system.

(d). Provider Monitoring. The Contractor shall monitor subcontracted provider QI activities to promote positive outcomes and ensure compliance with Federal and State laws, regulations, AHCCCS, ADHS, this Contract and all other QM requirements.

(e). Performance Improvement Projects (PIPs). The Contractor shall participate in the development, implementation, and reporting on performance measures and topics for PIPs as required by CMS, AHCCCS or ADHS, AHCCCS AMPM Chapter 980 and described in the CRS QM Plan, including performance improvement protocols or other measures as directed by ADHS. Each PIP must be completed within a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on QOC each year and as needed. Accordingly, the Contractor shall complete PIP data collection and other PIP-related tasks within the timeframes defined by ADHS.

(f). Member Satisfaction. The Contractor shall participate in the Annual Member Satisfaction Survey as directed by ADHS.

(2). Specific QM Requirements

(a). Performance Improvement Projects (PIPs)

The Contractor shall work collaboratively with ADHS to produce an ongoing program of PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The PIPs shall

focus on clinical and non-clinical areas and include the following (42 C.F.R. 438.240(d)(1) and (d)(2)):
measurement of performance using objective quality indicators;
implementation of system interventions to achieve improvement in quality;
evaluation of the effectiveness of the interventions; and,
planning and initiation of activities for increasing or sustaining improvement.

ADHS may develop and submit a self-selected proposal to AHCCCS for a new PIP to be implemented each year by the Contractor.

The Contractor shall be responsible to continue with interventions and requests for data on the two PIPs currently in progress. The PIPs are described at http://www.azdhs.gov/phs/ocshcn/crs/crs_rfp_documents_links.htm.

ADHS and the Contractor shall have an ongoing quality assessment and performance improvement program for the services furnished to Members (42 C.F.R. 438.240(a)(1)).

(b). Performance Monitoring

i. The QM program and performance monitoring activities shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

ii. The Contractor shall (42 C.F.R. 438.240(b)(2) and (c)):

1). measure and report to ADHS its performance, using standard measures required by ADHS, or as required by AHCCCS or CMS;

2). submit to ADHS, data specified by ADHS that enables ADHS, AHCCCS or

CMS to measure the Contractor's performance.

iii. The Contractor must have in effect mechanisms to evaluate the quality and appropriateness of care delivered to Members with special healthcare needs (42 C.F.R. 438.240(b)(4)).

iv. The Contractor must have a process in place for internal monitoring of Performance Measure rates, using standard methodology established or adopted by ADHS, for each required Performance Measure.

(c). Performance Standards (42 C.F.R. 438.240(a)(2), (b)(2) and (c))

AHCCCS has established two levels of performance for ADHS and its Subcontractors:

i. Minimum Performance Standards – A Minimum Performance Standard (MPS) is the minimally expected level of performance by the Contractor.

ii. Goals – A Goal is the ultimate benchmark to be achieved. If the Contractor has already achieved or exceeded the MPS for any performance measure, the Contractor must strive to meet the Goal for that measure. If the Contractor has achieved the Goal, the Contractor is expected to maintain this level of performance in future years.

The Performance Standards described below apply to all Members. The Contractor must meet MPSs, however, it is equally important that the Contractor continually improve its performance measure outcomes from year-to-year. The Contractor shall strive to meet the Goals established by ADHS and AHCCCS.

Anytime the Contractor's performance is below the MPS, ADHS may require a CAP and/or may impose sanctions. The CAP must be received by ADHS within

thirty (30) days of receipt of notification of the need for corrective action from ADHS, unless otherwise noted. This plan must be approved by ADHS prior to implementation. ADHS may conduct one or more follow-up on-site reviews to verify compliance with a CAP.

(d). Performance Measures

The Performance Measures are currently defined as follows:

i. Determination of Medical Eligibility: The percent of applications for which the Applicant was notified within fourteen (14) days of the receipt of the Referral. Each application received by the Contractor will result in a determination that:

1). the Applicant was Eligible for services; or

2). the Applicant was not Eligible for services; or

3). the application was incomplete* and could not be processed.

If the application could not be processed because it was incomplete, and information is later received to complete the application, the completed application will be handled as a new application for the purposes of calculating this performance measure.

* *A complete CRS Referral Form is one that includes information in all the required fields to be submitted on the form, as specified in the CPPM, Chapter 4.0.*

ii. First CRS Service: The percent of Members enrolled in CRS who receive their first CRS service within forty-five (45) calendar days of Enrollment or within the timeframes as specified in the initial Service Plan.

ADHS will identify a sample of Members and either request the Contractor to provide the medical record or other hard copy documentation for validation purposes, or perform such validation during site visits.

When requested by ADHS, the Contractor shall submit data for Performance Measures and/or PIPs within specified time lines and according to ADHS procedures for collecting and reporting the data. Using qualified staff, the Contractor shall collect accurate, complete and reliable data. The Contractor shall complete data collection in the format and by the due date specified. Any request for additional time to collect and report data must be made in writing in advance of the due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

Performance Measure definitions and evaluation methodologies are subject to change by ADHS. The following table identifies the MPS and Goals for each Measure.

Performance Measure	Minimum Performance Standard	Goal
Determination of Medical Eligibility	75%	90%
First CRS Service	75%	90%

Additional Performance Measures to which Performance Guarantees and Incentives are attached are described in the Financial Management and Practices subsection entitled Performance Guarantees and Incentives and in Exhibit C.

(e). Quality of Care Investigations

The Contractor shall investigate, analyze, track, trend and resolve QOC concerns consistent with AHCCCS AMPM Policy 920, ACOM 206 and Chapter 12 of the CPPM, including the following:

i. investigation of the QOC issue(s);
ii. conducting follow-up with the Member to determine that immediate care needs are met;
iii. referring QOC issues to the Contractor's Peer Review Committee, when appropriate;
iv. referring or reporting the QOC issue to the appropriate regulatory agency, Child or Adult Protective Services and ADHS for further research, review or action, when appropriate;
v. notifying ADHS and the appropriate regulatory or licensing board or agency when a provider is suspended or terminated due to QOC concerns; and
vi. documenting QOC issues in a data format as required by ADHS.

The Contractor and its Subcontractors shall cooperate with unannounced, on-site, focused reviews of the Contractor or its Subcontractors to investigate QOC issues and/or validate completion of CAPs.

(f). Peer Review Committee

The Contractor shall create and maintain an independent Peer Review Committee consistent with AHCCCS AMPM 910 and the CPPM. The Contractor shall, in a timely manner, provide Peer Review outcomes, corrective actions, and decisions to ADHS Quality Management Division.

The Contractor shall participate in the CRS Peer Review Committee as provided in the CPPM. The Contractor shall make available required participants as directed by the CRS Medical Director. Additionally, the Contractor shall fully implement recommendations of the CRS Peer Review Committee.

Cases referred to Peer Review include, but are not limited to:

i. questionable clinical decisions, lack of care, abandonment;
ii. trends of over or under utilization;
iii. pattern of inappropriate interpersonal interactions;
iv. decisions resulting from Fraud and Abuse investigations;
v. physical, psychological or verbal abuse;
vi. allegations of criminal actions related to practice;
vii. life threatening or dangerous events for the Member;
viii. unanticipated death of a Member;
ix. pattern of issues that have the potential for adverse outcome; and
x. pattern of allegations.

(g). QM Meetings

The Contractor's Medical Directors and Administrators shall meet at least quarterly with the CRS Medical Director and Administrators and other representatives of CRS to address program issues and opportunities for improvement.

(h). QM Deliverables

The Contractor shall provide the QM reports and conduct performance monitoring as required in Exhibit B of this Contract.

B. Medical Management/Utilization Management Requirements

(1). Overview and General MM/UM Requirements

(a). The Contractor and its Subcontractors shall ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. The

Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of Diagnosis, type of illness, or condition of the Member (42 C.F.R. 438.210(a)(3)(i),ii), and (iii)) unless it is outside the scope of Covered Services. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The Contractor shall not implement Prior Authorization or Concurrent Review processes or operations that cause undue burden to the Member or provider or contribute to delays in the Member obtaining needed services.

(b). The Contractor shall conduct MM/UM Statewide for the Enrolled CRS population as described in this Contract and all documents incorporated by reference, the Contract and its Amendments, and the Offeror's proposal and its Amendments.

(c). The Contractor shall have sufficient qualified staff to process Prior Authorization and Concurrent Review requests consistent with required time lines for expedited and standard review processes and to perform other MM/UM requirements. The Contractor and its Subcontractors shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions including training, and monitoring, and consulting with the requesting provider when appropriate (42 C.F.R. 438.210 (b)(2).

(d). The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the Managed Care requirements identified in the CPPM and this Contract including the process for initial and continuing authorizations of services (42 C.F.R. 438.210(b)(1)).

(e). The Contractor shall comply with Chapter 1000 of the AHCCCS AMPM

http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap1000/11_05Chap1000.pdf, the CRSA MM/UM Plan and Chapter 11.0 of the CPPM. The Contractor shall comply with Federal utilization control requirements, including the certification of need and recertification of need for continued stay in inpatient settings. The Contractor shall require licensed facilities to comply with Federal requirements regarding Utilization Review plans, Utilization Review committees, plans of care, and medical care evaluation studies as prescribed in 42 C.F.R., Parts 441 and 456. The Contractor shall actively monitor Subcontractors' UM activities for compliance with Federal regulations, AHCCCS and CRS requirements, and adherence to the UM Plan.

(2). Specific MM/UM Requirements

The following requirements shall be conducted consistent with AHCCCS AMPM Chapter 1000 and CPPM Chapter 11:

(a). To determine if a service is a medically necessary Covered Service, the Contractor shall apply the State's definition of Medically Necessary, the InterQual Level of Care Criteria, and relevant requirements from Chapters 5.0 and 6.0 of the CPPM to the Authorization Request.

(b). The Contractor shall not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any member.

(c). The Contractor shall not structure provider subcontracts to provide incentives to deny, limit, or discontinue Medically Necessary Services to a Member.

(d). The Contractor shall develop and implement processes, based in part on encounter data and medical record audits, that monitor for under- and over-utilization of services (42 C.F.R. 438.240(b)(3)). The Contractor shall actively monitor and analyze utilization and cost data for Covered Services. When the Contractor detects over- or under-utilization, the Contractor shall develop and implement strategies to bring utilization to the appropriate level.

(e). The Contractor shall conduct pharmacy Utilization Review.

(f). The Contractor shall maintain a Formulary that, at a minimum, contains the medications listed on the CRSA Medication Formulary http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/crs_formulary_2007_10_24.pdf.

(g). The Contractor shall conduct Concurrent Review of inpatient stays in accordance with Chapter 11.0 of the CPPM and shall include processes for decertification, facility transfers and discharge planning.

(h). The Contractor shall conduct Retrospective Review of services, including Emergency Services.

(i). The Contractor shall evaluate new medical technologies and new uses of existing technologies.

(j). The Contractor shall provide technical assistance to providers regarding MM/UM.

(3). Authorization and Denial Requirements

(a). The Contractor shall have an authorization process for non-emergency services consistent with Chapter 11.0 of the CPPM.

i. The Contractor requirements for Prior Authorization shall include, but not be limited to:

1). All non-emergent inpatient surgeries and medical admissions,
2). Purchase of Durable Medical Equipment (DME) and customized adaptive aids,
3). Outpatient Out-of-Network diagnostic tests and laboratory services,
4). Outpatient positron emission tomography scans,
5). Non-emergent transportation services between network facilities,
6). Outpatient ambulatory surgery services,
7). Implantable bone conduction devised and tactile hearing aids,
8). Non-formulary pharmacy requests.

ii. The Contractor shall perform Concurrent Review of inpatient hospitalizations.

iii. A provider shall obtain Prior Authorization as required by the Contractor prior to delivering services to a Member.

(b). Any decision to deny a service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's condition or disease consistent with AHCCCS AMPM Policy 1020 and 42 C.F.R. 438.210(b)(3).

(c). In the event that the Contractor or its Subcontractor fails to render a timely response to a service Authorization Request from a Health Plan/Program Contractor, this constitutes an action and the Contractor will send the enrollee a Notice of Action (42 C.F.R. 438.400(b) and 438.404(c)(5)). The Health Plan/Program Contractor may subsequently review the request and issue a favorable Prior Authorization determination. In this instance, the Contractor or its Subcontractors cannot contest the Health Plan/Program Contractor's Prior Authorization determination. If the AHCCCS hearing decision determines that the service should have been provided by CRS, the Contractor shall be financially

responsible for the costs incurred by the Health Plan/Program Contractor in providing the service.

Emergency Services are not subject to the Contractor's Prior Authorization. Providers are requested to notify the Contractor within twenty-four (24) hours or "next working day" of Emergency Services delivered; however, payment cannot be denied based on the provider's failure to notify the Contractor (42 C.F.R. 438.114(b)(1)(ii)).

All Prior Authorization, concurrent and retrospective decisions are subject to Retrospective Review by the Contractor consistent with Chapter 11.0 of the CPPM.

(d). Notices of Action

When any CRS Covered Service subject to Prior Authorization or Concurrent Review is denied, reduced, suspended or terminated, the Contractor shall comply with the Notice of Action and related timeliness, language and content requirements as detailed in 42 C.F.R. 438.210(d), 438.400 et seq., ACOM Policy and Guide 414 and Chapter 11.0 of the CPPM. The Contractor must notify the AHCCCS Health Plan/Program Contractor of any denial or reduction of service.

(4). Practice Guidelines

The Contractor shall adopt, disseminate and apply the CRS Practice Guidelines consistent with CMS requirements in 42 C.F.R. §438.236. The Contractor shall use Practice Guidelines as a basis for Service Planning requirements, MM/UM decisions, Member education, coverage of services and other areas to which the Practice Guidelines apply. At a minimum, the Contractor shall monitor Practice Guidelines implementation by network providers.

The Contractor may propose additional Practice Guidelines to ADHS for approval by the CRS Medical Director prior to

use. Practice Guidelines must meet the following requirements:

(a). Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field;
(b). Consider the needs of the Members;
(c). Are adopted in consultation with contracting healthcare professionals; and
(d). Are reviewed and updated periodically as appropriate.

The Contractor shall make utilization management, service coverage and other determinations to which the Practice Guidelines apply consistent with the applicable Practice Guidelines.

The Contractor shall disseminate the Practice Guidelines to providers, and upon request, to Members and their families. The Contractor shall also provide technical assistance to providers regarding implementation of Practice Guidelines.

The Contractor shall also utilize evidenced-based practices and other Standards of Care that are widely accepted in the medical field, as evidenced by endorsement by professional organizations such as the American Medical Association, as appropriate.

(5). MM/UM Deliverables

The Contractor shall provide the MM/UM reports described in Exhibit B as required, including completed Utilization Management Report Templates. To assist ADHS with interpretation of these reports, the Contractor shall report utilization information, taking into account claims IBNR. The Contractor shall only provide accurate and complete data consistent with reporting deadlines.

C. Member Services

The Contractor shall develop, implement and maintain a distinct Member Services function that is responsive to Potential Members, Members' families, providers and other stakeholders.

The Contractor shall provide Member Services for the CRS Eligible population as described in this Contract and all documents incorporated by reference, the Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall have a sufficient number of qualified staff with necessary experience and expertise to meet the Member Services requirements. The Contractor shall have a single toll-free Member Service telephone number, a Telecommunications Device for the Deaf (TDD) telephone number, and shall publicize both telephone numbers in local phone books, on its website, and in other written materials to Members and stakeholders.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the Member Services requirements identified in the CPPM and this Contract.

(1). Member Service Representatives (MSRs)

Member Service Representatives (MSRs) shall provide accurate information and effective assistance regarding CRS Eligibility and Enrollment; service requirements and benefits; navigation of the CRS system, AHCCCS Health Plans and Program Contractors, the CRS provider network, and family-support services available in communities to members and their families who call the Contractor's Member Services line. The MSR shall facilitate Referrals, Eligibility and Enrollment processes, respond to inquiries, and triage coverage, Prior Authorization, Grievance, Appeal, Claim Dispute and QOC issues.

The Contractor shall employ a sufficient number of MSRs to respond to inquiries during business hours. The Contractor may forward calls made to the Member Service line during non-business hours to an after-hours service.

At a minimum, the Contractor shall require MSRs to:

(a). interact with callers in a respectful, polite, and engaging manner;

(b). respond to inquiries and concerns from a Member, family members and stakeholders in a timely manner;

(c). respond to individuals with Limited English Proficiency (LEP) through use of appropriate language assistance services;

(d). process referrals including requests for services, assist with finding providers that are accepting referrals and scheduling appointments for services;

(e). assist the individual in telephonically connecting with the agency or other party to which he or she is referred;

(f). provide information on Eligibility, Enrollment, and how to access CRS services;

(g). assist with filing Grievances and Appeals; distinguish between an inquiry, a Grievance, an Appeal, a Claim Dispute and a QOC issue and know how to triage, resolve or refer calls to appropriate personnel; and

(h). inform Members and families about required documents needed to apply for AHCCCS.

(2). Member, Family and Other Stakeholder Communications

(a). Communication Content Requirements

At a minimum, the Contractor shall communicate the following information to Members and their families, providers, and other stakeholders:

i. how to become Eligible for enrollment in CRS, and access Covered Services;
ii. available treatment options for covered conditions;
iii. information to facilitate family members as decision-makers in the treatment planning process;
iv. Best Practices and Practice Guidelines related to CRS Conditions;

v. Member Service contact information, including toll-free telephone numbers;

vi. provider network directory and information regarding how to select or change a clinic, provider or Contractor (if applicable);

vii. how to file a Grievance, Appeal, Claim Dispute or request a State Fair Hearing; and

viii. information regarding the unique needs of children with CRS Conditions and the CRS program for public/private health care insurers, health care providers and students, regional and national health organizations, community groups and organizations and public health and school personnel.

(b). Member and Family Information Media Requirements

i. Written Communication Requirements

The Contractor shall develop and distribute Member and Family information and instructional materials to Members that are in an easily understood language and format in accordance with ACOM, 404 Member Information Policy. Regardless of the format chosen, the Member information shall be printed in a type, style and size that can be easily read by Members and families with varying degrees of visual impairment or limited reading proficiency. The Contractor shall notify its Members in writing that alternative formats are available upon request and how to access them. The Contractor shall obtain ADHS approval prior to distribution. Upon request, the Contractor shall assist ADHS in the dissemination of information to Members prepared by the Federal government, AHCCCS or ADHS.

Written information shall be translated into another language when three thousand (3,000) or ten percent (10%), whichever is less, of

Members enrolled with the Contractor, have LEP and speak that language.

All Vital Materials shall be translated into another language when one thousand (1,000) or five percent (5%), whichever is less, of the Members enrolled with the Contractor have LEP and speak that language. Vital materials include, at a minimum, notices for denials, reductions, suspensions or terminations of services, eligibility denials, consent forms and all written notices informing persons of their right to translation or interpretation services.

The Contractor shall provide Members with written notice of significant changes related to the CRS program, Member rights, Advance Directives, Grievances, Appeals or State Fair Hearings at least thirty (30) days in advance of the intended effective date.

The Contractor shall make oral interpretation services and alternative formats available upon request free of charge to all Members, including all non-English languages, not just those that the Contractor identifies as prevalent. The Contractor shall notify Members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

The Contractor shall, in all advertisements, publications, and printed materials that are produced by the Contractor and that refer to Title XIX and Title XXI Covered Services, state that the services are funded under a contract between AHCCCS and ADHS. The Contractor shall state in all advertisements, publications, and printed materials produced by the Contractor and that refer to Non-Title XIX, Non-

Title XXI Covered Services that the services are funded by ADHS.

ii. New Member Orientation Packet

The Contractor shall utilize, distribute and maintain the New Member Orientation Packet template provided by ADHS. The Contractor must provide the New Member Orientation packet to all Applicants within ten (10) Business Days of Enrollment in accordance with CPPM Chapter 1.0.

iii. Member Handbook

The Member Handbook is available at:
http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/english-handbook020107.pdf (English)
http://www.azdhs.gov/phs/ocshcn/pdfs_files/crs/spanish-handbook020107.pdf (Spanish)

The Contractor shall print and distribute the Member Handbook provided by ADHS in both English and Spanish. The Contractor shall distribute the Member Handbook to each newly enrolled Member within ten (10) Business Days of the Member Enrollment and at any time upon Member request.

iv. Contractor's Website

The Contractor shall develop and maintain a website containing information about the Contractor, the CRS system and Covered Services with links to important documents and forms including applicable guidelines, policies, manuals, statutes and rules. The Contractor shall organize the website to allow for easy access of information by Members, family members, providers, stakeholders, and the general public in compliance with the ADA and consistent with the ACOM Member Information

and Provider Network Information policies. The Contractor shall include on its website, at a minimum, the following information or links:

1). toll-free Member Service telephone number and contact information;
2). Telecommunications Device for the Deaf (TDD) telephone number;
3). hours of operations for the Contractor;
4). a provider directory that describes each provider's service, locations, contact information, language spoken; and any provider not accepting new patients;
5). the Member Handbook and a statement that the Member can request a Member Handbook at any time;
6). the CPPM;
7). Provider Manual;
8). Clinical Practice Guidelines Manual;
9). the ADHS Formulary;
10). information regarding the Statewide and Local PACs and other family organizations that provide opportunities for Members and their families to receive support and become involved;
11). a statement that welcomes feedback and directs the Member to instructions for filing a Grievance, Appeal or request for State Fair Hearing;
12). information on availability of interpretation services free of charge to Members and their families and how to access those services;
13). a hyperlink to the CRS website;
14). a hyperlink to the AHCCCS website
15). Information regarding Prior Authorization requirements, how to obtain Prior Authorization for services, and a statement that Prior Authorization criteria are available upon request;
16). CRS eligibility criteria and Referral practices;

17). Health Plan, Program Contractor and CRS coordination practices;
18). opportunities for Members and their families, providers and other stakeholders to provide feedback;
19). satisfaction survey and Performance Measurement results, if available;
20). interactive claims status inquiry site;
21). instructions about reporting suspected Fraud and Abuse; and
22). other documents as required by ADHS.

(3). Member Rights

The Contractor shall fully inform Members and their families about their rights and responsibilities and how to exercise them.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that are consistent with ACOM Chapter 400 to protect and enforce Member rights, including but not limited to, the guaranteed right to:

- be treated fairly regardless of race, religion, gender, age or ability to pay;
- receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
- participate in decisions regarding his or her healthcare, including the right to refuse treatment;
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- request and receive a copy of his or her medical records, and/ or inspect medical records, at no cost and to request that the records be amended or corrected, as specified in 45 C.F.R. part 164;
- know about providers who speak languages other than English; and
- a second opinion from a qualified health care professional within the network, or a second opinion

arranged outside the network, only if there is inadequate in-network coverage, at no cost to the Member.

(a). Mainstreaming of Members

To ensure mainstreaming of Members, the Contractor shall take affirmative action so that Members are provided CRS services without regard to payer source, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, or physical or cognitive disability, except where medically indicated. The Contractor and its Subcontractors must take into account a Member's culture when addressing Members and their concerns in compliance with Chapters 6.0 and 13.0 of the CPPM and the CRSA Cultural Competency Plan. .

Examples of prohibited practices include, but are not limited to, the following:

i. denying or not providing a Member any covered service or access to an available facility that would not be denied or provided to other Members in similar circumstances;
ii. providing to a Member any Covered Service that is different, or is provided in a different manner, or at a different time or place from that provided to other Members, other public or private patients or the public at large, except where medically necessary, on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or cognitive disability of the participants to be served; and
iii. subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a Member in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.

(b). Advance Directives

In accordance with 42 C.F.R. 438.6(i)(1) and 422.128, the Contractor shall maintain policies and procedures addressing Advance Directives for Adult Members consistent with Subpart I of part 489. For the purposes of the Advance Directives, an Adult Member is an individual who is eighteen (18) years of age or older.

i. Each contract or agreement with a Hospital, nursing facility, home health agency, hospice or organization responsible for providing care, must comply with Federal and State law regarding Advance Directives for Adult Members. Requirements include:

1). maintaining written policies that address the rights of Adult Members to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an Advance Directive;

2). if an agency/organization has a conscientious objection to carrying out an Advance Directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. §36-3205.C.1;

3). providing written information to Adult Members regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning Advance Directives (including any conscientious objections) (42 C.F.R. 438.6(i)(3));

4). documenting in the Member's medical record whether or not the Adult Member has been provided the information and whether an Advance Directive has been executed;

5). not discriminating against a Member because of his or her decision to execute or not execute an Advance Directive, and not making it a condition for the provision of care; and

6). providing education to staff on issues concerning Advance Directives including notification of direct care providers of services, such as home health care and personal care, of any Advance Directives executed by Members to whom they are assigned to provide services.

ii. The Contractor shall ensure providers that have agreements with the entities described in paragraph G.3.b.i. above comply with the requirements. ADHS shall also encourage health care providers specified in subparagraph G.3.b.i. above to provide a copy of the Member's executed Advance Directive, or documentation of refusal, to the acute care PCP for inclusion in the Member's medical record.

iii. The Contractor shall encourage family members of CRS Members who are children to discuss and make advance plans for decisions regarding medical care.

iv. The Contractor shall ensure that Adult Members are provided written information describing the following:

1). a Member's rights under State law, including a description of the applicable State law;

2). policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;

3). the Member's right to file Grievances directly with ADHS and AHCCCS; and,

4). changes to State law as soon as possible, but no later than ninety (90) days after the effective date of the change (42 C.F.R. 438.6(i)(4)).

v. When referring patients to providers, the Contractor and its Subcontractors shall take into account Member preferences and needs, the specific providers recommended by the referring provider (if any), network status, continuity of care, geographic proximity and ability to travel.

(4). Medical and Other Records

(a). The Contractor shall maintain all medical and other records (including Applicant records) in accordance with Chapter 9.0 of the CPPM, AHCCCS AMPM Policy 940, and 42 C.F.R. Part 456 and 45 C.F.R. parts 160 and 164. The Contractor shall have written policies and procedures to ensure that an Integrated Medical Record for each Member is maintained for ready access by a multi-specialty treatment team. An Integrated Medical Record shall contain all of the information necessary to facilitate the coordination and QOC delivered by multiple providers in multiple locations at varying times. In addition, the Contractor shall participate in the AHCCCS Health Information Exchange, Electronic Medical Record project (HIeHR) to develop an electronic integrated medical record.

(b). The Contractor shall have written standards for documentation on the medical record for legibility, accuracy and plan of care that comply with the AHCCCS AMPM. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical record entries must be legible, signed and dated.

(c). The Member's medical record is the property of the provider who generates the record except as provided

by the Uniform Terms and Conditions, “Property of the State” Section 3.7. The Contractor shall have written policies and procedures to ensure the confidentiality of all medical and other records as applicable. Each Member is entitled to one copy of his or her medical record free of charge and to request that they be amended or corrected as specified in 45 C.F.R. part 164.

(d). The Contractor shall respond to record requests in a timely manner and share, store and maintain records in accordance with State and Federal law, relevant accrediting body requirements and approved policies and procedures.

(e). Following termination of this Contract, ADHS shall designate a provider to whom the Contractor shall transfer the medical and other records of all Members within fifteen (15) days of the Contract termination date. The Contractor shall also supply an alphabetical list of Members with the Contractor’s assigned medical record number and CRS identification number.

(f). AHCCCS, ADHS and representatives of the Federal government may inspect Medical and other records at any time during regular business hours at the offices of ADHS, the Contractor’s, contracted facilities, or other service providers.

(g). AHCCCS, ADHS and representatives of the federal government may obtain a copy of a Member's medical and other records without written approval of the Member if the reason for such request is directly related to the administration of the AHCCCS or CRS program.

(5). Written Notices

The Contractor shall provide all notices to Members and their families in accordance with the requirements set forth in the CPPM. At a minimum, the Contractor shall ensure that:

(a). Notices of Action for denials, reductions, suspensions or terminations of services, and Notices of Extension of Timeframe for Service Authorization Decisions (NOEs) are delivered in compliance with the language, timeframe, and content requirements of 42 C.F.R. 438.210, 438.400 et seq., the ACOM, Chapter 11.0 of the CPPM, and this Contract.

(b). When the Contactor terminates a subcontract with a provider, the Contractor shall deliver written notice of termination within fifteen (15) days of receipt or issuance of the termination notice to each Member that received services from or was seen on a regular basis by the terminated provider.

(6). Local and State Parent Action Council

The Statewide PAC is comprised of parent representatives from local Parent Action Councils (PACs), and a representative from an advocacy group, the Contractor, and ADHS. PACs provide a network and meeting forum for sharing ideas and exchanging information to improve the health care system for children with special health care needs. The PACs promote parental involvement in treatment planning, advocacy, and patient care, and participate in processes that change laws, rules, policies and procedures related to children with special health care needs.

A PAC representative shall participate in Contractor functions as required by A.R.S. §36-265 and Chapter 6.0 of the CPPM. The Contractor shall fund PAC activities as required by ADHS. A PAC representative shall also attend quarterly meetings with the ADHS and Contractor Medical Directors and Administrative representatives.

(7). Member Services Deliverables

The Contractor shall monitor the performance of the MSRs and document the results including Call Volume, Call Type and Language Line Usage monthly as listed in Exhibit B. Corrective actions will be taken when requirements are not met. The Contractor shall track inquiries and analyze trends quarterly, identifying problem areas and taking actions to improve on both an individual and systemic basis.

D. Grievances, Appeals and Provider Claim Disputes

The Contractor shall have in place a Grievance System, for Subcontractors, Members, families, providers and non-contracted providers regarding disputed matters with the CRS program which shall be in accordance with Federal and State laws, regulations, including A.A.C. Title 9, Chapter 34, AHCCCS and ADHS policies, this Contract and all documents incorporated by reference, Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall have a sufficient number of qualified personnel with the experience and expertise to implement and maintain the Grievance, Appeals, Claim Dispute and State Fair Hearing processes. The Contractor shall not delegate or subcontract the administration of processes for Grievances, Appeals or Claim Disputes.

The Contractor shall provide the professional, paraprofessional, or administrative resources necessary to represent the Contractor's or Subcontractor's interests at administrative or judicial proceedings for issues related to the Contractor's or its Subcontractors' decisions or actions, unless the issue relates to a Claim Dispute. For administrative or judicial proceedings on Claim Disputes, the provider shall provide its own legal representation, and the Contractor shall provide its own professional, paraprofessional or administrative resources necessary to represent its interests.

The Contractor shall have written policies and procedures for the provision of required notices to Members, providers, non-contracted providers and for reviewing, evaluating, responding to and resolving Grievances, Appeals, and Claim Disputes and access to State Fair

Hearings. At a minimum, the Contractor's policies and procedures shall address who may file, requirements for a Grievance, Appeal or Claim Dispute standard and expedited timeframes, processes, required notices and how a Member gains access to a State Fair Hearing. The Contractor shall also have a written policy and procedure for requests for review by AHCCCS Health Plans/Program Contractors in compliance with ACOM Chapter 409 and CPPM Chapter 8.0.

The Contractor shall provide the Grievance System policies to all providers at the time of Subcontract. The Contractor shall notify Members of the Grievance System requirements through the Member Handbook.

The Contractor shall ensure that punitive action is not taken against a provider who supports a Member's Grievance, Appeal or requests for an expedited resolution to an Appeal or State Fair Hearing.

The Contractor shall fully cooperate with ADHS when ADHS decides to participate in or review any Grievance, Appeal, State Fair Hearing or Claim Dispute. The Contractor shall implement ADHS's decisions pending the formal resolution of the issue. The Contractor shall, in a timely manner provide the ADHS Office of Grievance and Appeals with any requested information for ADHS's oversight of these processes.

The Contractor shall authorize or provide disputed services promptly, and as expeditiously as the Member's health condition requires if the services were not furnished while the Appeal was pending and the ADHS or the State Fair Hearing officer reverses a decision to deny, limit, or delay services.

The Contractor shall pay for disputed services, in accordance with State policy and regulations, if the Contractor or AHCCCS Director reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending.

The Contractor's Grievance, Member Eligibility Appeal, Expedited and Standard Appeals for Title XIX and Title XXI Members, Non-Title XIX/XXI Appeals, and Claim Disputes shall consist of the following processes in compliance with all applicable Federal and

State laws, the CPPM, and this Contract, including all documents incorporated by reference.

(1). Grievances

The Contractor shall develop and maintain a Grievance process consistent with CPPM Chapter 8.0, A.R.S. §36-2903.01(B)(4); A.A.C. R9-34-210 et seq. The Contractor and its Subcontractors must accept, resolve and track Member Grievances as required by the ACOM Enrollee Grievance Policy.

(2). Appeals

(a). The Contractor shall develop and maintain an Eligibility Appeal process consistent with CPPM Chapter 8.0, which includes notice requirements to the Member and the right to a State Fair Hearing.

(b). The Contractor shall develop and maintain a standard and expedited Appeal process for Title XIX and XXI Members that is consistent with A.A.C. R9-34-201 et seq; CPPM Chapter 8.0 and A.A.C. R9-7-701, which provide Members with required notices of the right to Appeal Actions of the Contractor or its Subcontractors and provides Members with the required notices of the right to request a State Fair Hearing for adverse Appeal decisions by the Contractor.

(c). The Contractor shall develop and maintain an Appeal process for Non-Title XIX/Title XXI Members that is consistent with A.A.C. R9-7-701, which includes notice requirements to the Member and the right to a State Fair Hearing.

(3). Provider Claim Disputes

The Contractor shall develop and maintain a Claim Disputes process consistent with A.R.S. §36-2903.01(B)(4); A.A.C. R9-34-401 et seq., and CPPM Chapter 7.0 to resolve Claim Disputes related to payment or denial of a claim, or the imposition of a financial sanction by the Contractor. The

Contractor shall develop and maintain processes to screen all Claim Disputes, collectively and individually, for potential Fraud or Abuse.

(4). State Fair Hearing Process

The Contractor shall develop a process to facilitate expedited and standard State Fair Hearing requests consistent with the CPPM Chapter 8.0 and consistent with 42 C.F.R. Part 438 Subpart F and 431.200 et al. The process shall address the Members' or providers' right to a State Fair Hearing, a method for obtaining a State Fair Hearing and the rules that govern representation at the hearing.

(5). Notice of Grievance and Appeal Rights

The Contractor shall ensure that it provides written information to Members and providers in a timely manner that clearly explains the Grievance System requirements as described in CPPM Chapter 8.0, A.R.S. §36-2903.01(B)(4); A.A.C. R9-34-210 et seq.. This information must include a description of: the right to a State Fair Hearing, a method for obtaining a State Fair Hearing, the rules that govern representation at the Hearing, the right to file Grievance, Appeals, and Claim Disputes, the requirements and timeframes for filing Grievance, Appeals and Claim Disputes, the availability of assistance in the filing process, the toll-free numbers that the Member can use to file a Grievance or Appeal by phone (that the Contractor shall reduce to writing), that benefits will continue when requested by the Member in an Appeal or State Fair Hearing request concerning certain Actions that are filed in a timely manner, that the Member may be required to pay the cost of services furnished during the Appeal/Hearing process if the final decision is adverse to the Member, and that a provider may file an Appeal on behalf of an Member with the Member's written consent. Information to Members must meet Cultural Competence and LEP requirements as specified this Contract. The Contractor shall utilize relevant ADHS templates for Notices and correspondence.

(6). Grievance, Appeal, Request for State Fair Hearing and Claim Dispute Case Records

The Contractor shall maintain separate case records for each Grievance, Appeal, Request for Hearing or Claim Dispute. The Contractor shall maintain the case records in a secure designated area and retain them in a reproducible format for a minimum of six (6) years. Each case record must contain all documents generated, acquired, or relied upon throughout the process, as well as any documentation explicitly required by the CPPM.

(7). Grievance System Reporting and Deliverables

The Contractor must submit to ADHS the AHCCCS Grievance System Report, using the AHCCCS Quarterly Grievance System Reporting Guide and Report Templates, no later than fifteen (15) days from the end of each month as listed in Exhibit B.

The Contractor shall trend and analyze Grievance, Appeals and Claim Disputes at least monthly and any identified trends and CAPs shall be reported to ADHS with the AHCCCS Grievance System Report.

2. Service Delivery

In partnership with ADHS, the Contractor shall arrange for the delivery of multi-specialty, interdisciplinary services that are person- and Family-Centered, timely, culturally responsive, and effective in reducing symptoms stemming from Members' conditions, thus, maximizing functioning and improving Members' quality of life. The Contractor shall be proactive, collaborative and innovative in organizing, operating, and administering a delivery system that meets the service needs of Members.

The Contractor shall deliver services Statewide for the Enrolled CRS Eligible population as described in this Contract and all documents incorporated by reference, Contract Amendments, and the Offeror and its Amendments.

The Contractor shall have a sufficient number of qualified staff with necessary experience and expertise to arrange for the delivery of services.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the Eligibility, Enrollment and Service Delivery requirements identified in CPPM and this Contract.

A. Eligibility Determinations and Enrollment

(1). Eligibility Determination

The Contractor shall develop, implement, and monitor compliance with written policies and procedures consistent with the CPPM and this Contract regarding Eligibility Determinations and Enrollment processes. The Contractor shall provide all notifications of Eligibility Determinations in accordance with chapter 4.0 of the CPPM.

Following receipt of a Referral as described in R9-7-301, the Contractor's Medical Director or designee shall screen documentation provided to assess whether an Applicant is likely to meet CRS Eligibility criteria. If the Applicant appears to meet the Eligibility criteria, the Contractor shall notify the Applicant, Referral source and Applicant's Health Plan and Program Contractor within fourteen (14) days of receipt of the Referral regarding the Eligibility Determination and proceed with Enrollment.

If the Eligibility screening determines that the Applicant does not meet Eligibility criteria, the Contractor shall, consistent with the requirements of A.R.S. §41-1092.03 notify the Applicant regarding the Denial within fourteen (14) days of receipt of the Referral. In addition, within five (5) Business Days of the Denial determination, the Contractor shall notify the Referral source, the Applicant's AHCCCS Health Plan and Program Contractor of the Denial determination in writing. The Contractor is responsible for providing legal and medical professional representation for all subsequent administrative/legal proceedings with respect to decisions of Eligibility and terminations of Enrollment. Eligibility determinations and initial services shall occur consistent with

the requirements described in the Performance Measurement section of this Scope of Work.

If the Eligibility screening cannot be completed from the documentation provided, the Contractor shall request additional information or schedule a physical examination within thirty (30) days of the Referral and complete the Eligibility screening.

(2). Enrollment

The Contractor shall require Applicants to complete the verification packet as described in R9-7-302.

(a). AHCCCS Enrollees

If an Applicant is already enrolled with AHCCCS, the Contractor shall consider the Applicant enrolled with CRS upon completion of an Assignment of Benefits form for the purposes of initiating CRS service.

(b). Non-AHCCCS Enrollees

If an individual is not enrolled with AHCCCS at the time of CRS Eligibility Determination, the Contractor shall conduct a financial screening as described in R9-7-303 to determine the Applicant's potential for AHCCCS eligibility. If deemed potentially eligible for AHCCCS, the Applicant must apply for AHCCCS enrollment to receive CRS assistance with payment for Covered Services. The Contractor may assist Applicants with applying for AHCCCS eligibility using the Health-e-Arizona Application. The Arizona Department of Economic Security (ADES) or AHCCCS is responsible for determining eligibility for AHCCCS.

The Contractor shall be responsible for delivery and payment of Covered Services for Members who are not AHCCCS eligible if the individual's family income is below two hundred percent (200%) of the FPL or a

lesser percentage as determined by ADHS, based on annual State appropriations.

If the financial screening determines that the Applicant's household income is less than 200% of the FPL (or a lesser percentage as determined by ADHS, based on annual State appropriations), the Contractor shall be responsible for all payments for CRS services. The contractor shall enroll the member upon the member's signing a payment agreement.

If the financial screening determines that the Applicant's household income is 200% or higher (or a lesser percentage as determined by ADHS, based on annual State appropriations), the contractor will not be responsible for payment for CRS services. The contractor shall enroll the member upon the member's signing a payment agreement. The contractor shall work with a member's private insurance company to coordinate benefits.

(3). Contractor Choice or Assignment

If more than one Contractor is awarded a Contract with ADHS, Members will be permitted to choose a Contractor. In the absence of Member selection, ADHS shall assign Members to Contractors.

(4). Appeals of CRS Eligibility Determinations

Appeals of CRS Eligibility Determinations shall be heard in a State Fair Hearing. Individuals who do not cooperate in the Eligibility and financial screening process will not be Enrolled.

(5). Eligibility and Enrollment Monitoring, Reporting and Deliverables

The Contractor shall monitor and report the timeliness of Eligibility Determinations, steps in the Enrollment process, and access to services listed in the initial Service Plan. The

Contractor shall submit the New Member Enrollment Report, the Cystic Fibrosis reports in accordance with Exhibit B. Annually, the Contractor shall provide ADHS its Medical Eligibility Criteria Policy as required in Exhibit B.

B. Service Delivery Requirements

The Contractor shall develop, implement, and monitor compliance with written policies and procedures consistent with the CPPM, Federal and State laws and this Contract related to the delivery of Covered Services and performance of the Service Delivery requirements in this section. In addition, the policies and procedures shall incorporate CRS Best Practices and Practice Guidelines including multi-specialty, interdisciplinary care; care coordination; continuity of care and transition planning; interagency collaboration, Family-Centered care and cultural and linguistic competence.

(1). Multi-Specialty, Interdisciplinary Care

The Contractor shall deliver multi-specialty, interdisciplinary Covered Services through a combination of established MSICs, Field Clinics, Virtual Clinics, and community settings. MSICs permit members of the treatment team, the Member and his or her family members to meet face-to-face to evaluate and plan treatment. Types of required MSICs are provided in Exhibit A. Field Clinics are provided by specialty providers who travel to locations closer to the homes of Members who are not conveniently located near MSICs. Virtual Clinics may also be implemented where treatment team members in community settings collaborate and conduct treatment planning through the use of Telehealth and an Integrated Medical Record. Regardless of the setting, the Contractor shall develop and implement organizational structures and procedures that promote collaboration and consultation among multi-specialty treatment team members.

(2). Care Coordination and Service Plans

The Contractor is responsible for delivering effective care coordination as described in Chapter 3.0 of the CPPM,

confirming that treatment is carried out as providers intended, and minimizing unnecessary disruption to Members' lives. When coordinating care, the Contractor shall protect each Member's privacy in accordance with HIPAA privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent applicable.

The Contractor shall coordinate care consistent with the Joint Principles of the Patient-Centered Medical Home, which can be located on the CRS website. Each Member shall have an ongoing relationship with a physician trained to provide continuous and comprehensive care. A physician will lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of Members. In addition to the Member and his or her family, medical specialists, therapists, providers of support services, and providers of general health care services, such as the Member's PCP, are part of the CRS treatment team and must be consulted, informed, and invited to participate in decision making regarding a Member's treatment. The physician is responsible to provide for all the Member's health care needs, or takes responsibility for appropriately arranging care with other qualified professionals through the Care Coordinator. Care is coordinated and/or integrated across all elements of the Member's community and complex health care system, including Out-of Network providers.

Upon Enrollment, the Contractor's Medical Director shall identify the date by which the Member shall receive the next Medically Necessary Service(s) in an initial Service Plan. Initial services shall be delivered no later than forty-five (45) days post-enrollment, unless alternative time lines are specified in the Service Plan that are supported by CRS Clinical Practice Guidelines and/or a Member's recent treatment history.

Subsequently, the Contractor shall require a Care Coordinator to maintain a Service Plan for each Member based on the treatment plans developed by the treatment team. The Service Plan is a document that combines the various elements of multiple treatment plans with needed

family support services and care coordination activities to provide a map of the steps to be taken for each Member to achieve treatment and quality of life goals. The Service Plan shall identify specific agencies or organizations with which treatment must be coordinated and address Member-specific barriers to treatment, such as use of Out-of-Network providers or a Member's or family's ability to travel, in compliance with CPPM Chapter 3.0.

In addition, the Service Plan shall identify the individual or entity responsible for service implementation and the dates by which the service shall be initiated. The Contractor shall monitor the Service Plan for timely development and update it as Members' needs change. The Contractor shall assist the Member and his or her family with adherence to the Plan through scheduling appointments, obtaining transportation, navigating Prior Authorization requirements, advocacy with the school district, or other Case Management strategies as needed.

For CRS Members enrolled with AHCCCS, the Contractor shall ensure that medical records (copies or summaries of relevant information) of each Title XIX and Title XXI member are forwarded to the Member's PCP as needed to support quality medical management and prevent duplication of services. At a minimum, the Contractor or its Subcontractors shall provide a consultation report to the referring physician and the Health Plan/Program Contractor within thirty (30) days of the first service. The report shall include the plan of care, a Diagnosis, and name, address and phone number of the CRS provider. Similarly, the Contractor shall ensure medical records for Non-Title XIX and Non-Title XXI Members are forwarded to the Member's PCP.

Coordination with the Arizona Department of Education (ADE) and the Local Education Agency (LEA), i.e., the Member's school district, is important for the purposes of ensuring the special needs of CRS Members are met, which may include appropriate school placement, Individual Education Plan (IEP) assistance, accommodation plans and continuation of homework assignments during and following hospital stays.

Services Members receive through other funding sources or agencies, such as the Arizona Department of Health Services, Division of Behavioral Health Services (DBHS) or the Arizona Department of Economic Security (ADES), Division of Developmental Disabilities (DDD), must also be integrated and coordinated into the Service Plan.

The Contractor shall establish policies and procedures for ensuring implementation and monitoring of coordination between Subcontractors, AHCCCS Health Plans, ALTCS Program Contractors, and other State agencies. The Contractor and ADHS shall monitor to ensure compliance with these coordination requirements through periodic case file review, trends in Grievance, Appeal and problem resolution data and other QM activities.

(3). Continuity of Care and Transition Planning

CRS Members often require care over an extended period of time, requiring transitions from the children's system to the Adult system of care, one Contractor to another, from inpatient to outpatient levels of care, or from the treatment of one physician to another. Accordingly, the Contractor shall implement specific strategies to preserve continuity of care during transitions in accordance with the CRSA Quality Management Plan and the CPPM.

The Contractor shall develop a Pediatric to Adult Transition Plan for each Member by age fourteen (14). The Transition Plan shall be developed with Members, families and their providers and include strategies to address barriers to transitioning from a pediatric-oriented to an adult-oriented system of care. The Plan should be age-appropriate, updated to address the Member's current needs and identify an Adult PCP prior to the Member's exit from CRS.

In addition to health care, developmentally-appropriate discussions related to work, education, recreation, and social needs should be part of planning for adulthood. All teens, including those with cognitive disabilities, should be included in planning for adulthood in a way that is meaningful to them.

For AHCCCS enrolled members, the Contractor shall adhere to the policies in the AHCCCS AMPM, Chapter 520 regarding Pediatric to Adult Transition Plans. Utilizing the Enrollment Transition Information (ETI) Form, the Contractor shall notify the Member's Health Plan/Program Contractor to begin Coordination of Care for the Member, ninety (90) days prior to the Member's twenty-first (21st) birthday as required in the AHCCCS AMPM, and the ACOM, Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy.

(4). Interagency Collaboration

In general, CRS provides specialty services related to the Member's CRS Condition, but does not cover other routine, preventive or acute non-specialized medical services. Accordingly, coordination with AHCCCS Acute Health Plans, ALTCS Program Contractors and American Indian Health Plan regarding issues of coverage and reimbursement is necessary to avoid administrative barriers with the potential to negatively impact timely service delivery.

(5). Emergency and Post-Stabilization Services

BBA, 42 C.F.R. 438.114, 422.113 and 422.133, states that a PIHP must cover and pay Emergency Services without Prior Authorization regardless of whether the services are received within or outside of the PIHP. AHCCCS Members shall be permitted to obtain Emergency Services immediately at the nearest provider when the need arises. When the Prudent Layperson standard is met, no restriction may be placed on access to emergency care.

The following conditions apply with respect to payment of emergency and post-stabilization services. The Contractor shall cover and pay for Emergency Services related to CRS Conditions when the provider that furnishes the service has a subcontract with the Contractor. The Contractor shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the

definition of Emergency Medical Condition. The Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructs the Member to seek Emergency Services. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 C.F.R. 438.114(b) as responsible for coverage and payment.

The AHCCCS Health Plan shall be responsible for Emergency Services that are related to CRS Conditions when delivered by a provider with which the Contractor does not have a subcontract. The AHCCCS Health Plan shall also be responsible for Emergency Services that are unrelated to CRS Conditions, even if delivered by a provider that has a subcontract with the Contractor.

The Contractor shall pay for post-stabilization services of a CRS-related condition when the provider that furnishes the service has a subcontract with the Contractor in the following situations:

(a). Post-Stabilization Care Services were prior-authorized by the Contractor;

(b). Post-Stabilization Care Services were not pre-approved by the Contractor or a Contractor representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

(c). A Contractor representative and the treating physician cannot reach agreement concerning the Member’s care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult

with a contracted physician and the treating physician may continue with care of the Member until a contracted physician is reached or one of the criteria in C.F.R. 422.113(c)(3) is met.

Pursuant to C.F.R. 422.113(c)(3) or 422.114(e) (c)(3), the Contractor's financial responsibility for Post-Stabilization Care Services that have not been pre-approved ends when a contracted physician with privileges at the treating Hospital assumes responsibility for the Member's care; a contracted physician assumes responsibility for the Member's care through transfer; a representative of the Contractor and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

(6). Family-Centered Care

The Contractor shall share information and collaborate with family members to promote family decision-making in all aspects of the planning, delivery and evaluation of health care services for Members. Specifically, the Contractor and its Subcontractors shall provide information to family members using communication media and language that are easy to understand. Based on their knowledge about the needs of children with special healthcare needs and their families, providers shall refer to special education, respite, community agencies, or other health care providers. Decisions regarding treatment, equipment, therapy, and other services shall be based on input from family and provider teams. When possible, Members shall receive care close to home and at convenient times and treatment settings, including physician offices.

(7). Culturally and Linguistically Competent Services

The Contractor shall provide culturally and linguistically responsive services in accordance with the requirements in Chapters 6.0 of the CPPM and the CRSA Cultural Competency Plan.

The Contractor shall subcontract with providers whose services are delivered by individuals with an awareness of and sensitivity to the culture and socio-economic conditions of the communities in which Members and their families live, as well as the way the experience of living with and adapting to special health care needs affect their lives.

Services shall be delivered using the preferred language of the Member and his or her family when possible. If the Member and his or her family have LEP and a provider does not speak the preferred language of the Member or a family member, the Contractor shall utilize qualified service providers to deliver sign language, translation and interpretation services or provide alternative formats upon request. Neither the Contractor nor any network provider shall require, encourage, or rely on a family member, friend or other non-professional provider of interpretation services to provide such services to the Member.

(8). Provider-Member Communications

The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a Member regarding medical needs and treatment options, even if the Member needs or services are not Covered Services or if an alternate treatment is self-administered. The Contractor shall encourage providers to communicate information to assist a Member to select among relevant treatment options, including the risks, benefits and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her care; the right to refuse treatment and to express preferences about future treatment decisions. For AHCCCS enrolled members, the Contractor shall allow for a second opinion from a qualified Health Care Professional within the network, or if one is not available in network, arrange for the Member to obtain one outside the network, at no cost to the Member consistent with 42 C.F.R. 438.206(b)(3).

(9). Moral or Religious Objections to Covered Services

The Contractor must notify ADHS if, on the basis of moral or religious grounds, it elects to not provide, reimburse for, or provide coverage of a covered counseling or referral service. Notification must be submitted prior to entering into a Contract with ADHS or whenever it adopts the policy during the term of the Contract. The notification and policy must be consistent with the provisions of 42 C.F.R. 438.10. The Contractor must notify Members of the policy during their initial enrollment; and notification must be provided to Members at least thirty (30) days prior to the effective date of the policy. The notification and policy must be consistent with the provisions of 42 C.F.R. 438.10.

(10). Monitoring, Reporting and Deliverables

The Contractor shall monitor, report, and submit deliverables related to service delivery as described in Exhibit B.

D. NETWORK DEVELOPMENT AND MANAGEMENT

The Contractor shall deliver services through a Statewide provider network for the Enrolled CRS population as described in this Contract and all documents incorporated by reference, Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall have a sufficient number of qualified staff with necessary experience and expertise to effectively develop and manage the network.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the network development and management requirements identified in the CPPM and this Contract. The Contractor shall not delegate any part of network management to another entity without the prior approval of ADHS.

1. Network Development Requirements

A. Network Adequacy

The Contractor shall employ or contract with a Statewide provider network of sufficient size and scope to deliver all covered CRS

medical and support services needed by Members and to offer a choice of provider when feasible. The network shall be comprised of providers who deliver high quality services. The Contractor shall design the network prioritizing the needs and convenience of Members and their families. Members shall have access to well-coordinated services delivered by qualified providers in a culturally competent, linguistically appropriate, Family-Centered manner that is at least equal to community norms. Covered services shall be reasonably available in terms of location, hours of operation and waiting times.

B. Network Provider Types

The Contractor's provider network shall include, but is not limited to, the following provider types:

(1). physicians licensed, as appropriate, by the Arizona Medical Board, the Arizona Board of Osteopathic Examiners; all specialty physicians will be Board Certified/Eligible by their respective specialty boards and have hospital privileges as necessary to provide services to Members;

(2). dentists licensed by the Arizona State Board of Dental Examiners. Specialists shall be Board Certified/Eligible by a specialty board recognized by the American Dental Association;

(3). nurses licensed by the Arizona State Board of Nursing; advance practice nurses shall have State and National certification; and advance practice nurses with prescription privileges must have a DEA license;

(4). physician assistants licensed by the Arizona Regulatory Board of Physician Assistants, who will only prescribe medication if delegated by the physician in accordance with A.R.S. §32-2532;

(5). audiologists and speech-language pathologists licensed by the Arizona Department of Health Services Division of Licensing Services Special Licensing Team and certified by the American Speech-Language-Hearing Association (ASHA);

(6). orthotists and prosthetists certified by the American Orthotic & Prosthetic Association or the Board for Orthotist/Prosthetist Certification;

(7). hearing aid dispensers licensed by the ADHS Division of Licensing Services Special Licensing Team;

(8). pharmacists licensed by the Arizona State Board of Pharmacy;

(9). psychologists licensed by the Arizona Board of Psychologist Examiners;

(10). occupational therapists licensed by the Arizona State Board of Occupational Therapy Examiners;

(11). physical therapists licensed by Arizona State Board of Physical Therapy Examiners;

(12). dietitians registered through the American Dietetic Association;

(13). social workers licensed through the Arizona Board of Behavioral Health Examiners;

(14). Child life specialists who, at a minimum, have a Bachelor's degree in child development or closely related field or equivalent demonstrated experience in Child life services. Individuals with Child Life Certification are preferred;

(15). other ancillary personnel/facilities including those that provide pharmacy, laboratory and radiology services licensed or certified if required by The Joint Commission or other nationally recognized accrediting body;

(16). Inpatient facilities, outpatient facilities and ambulatory surgery facilities licensed by ADHS, certified by the State Medicare Licensing Body or CMS and/or accredited by The Joint Commission, the Accreditation Association for Ambulatory Health Care or other nationally recognized accrediting body. Outpatient facilities dispensing hearing

aids with a Corporate Hearing Aid Dispensing License issued by ADHS; and

(17). providers practicing outside the State with similar licensing/certification as required by their respective state laws.

All providers shall conform to regulations set by the Occupational Safety and Health Administration (OSHA) and practice infection control precautions as recommended by the Centers for Disease Control and Prevention (CDC).

The Contractor shall use an up-to-date Telemedicine system to improve Access to Care for Members who do not reside within a reasonable traveling distance to needed services and to improve the efficient utilization of providers in the Contractor's network.

C. Selection and Retention of Providers

(1). Each provider shall register with the AHCCCS through www.azahcccs.gov .

Each provider who is not already an AHCCCS registered provider shall sign a Provider Participation Agreement. The Contractor shall forward the original Agreement to AHCCCS.

(2). The Contractor shall not discriminate against any provider with respect to participation in the CRS program, reimbursement or indemnification based solely on the provider's type of licensure or certification. (42 C.F.R. 438.12(a)(1)). This provision, however, does not prohibit limiting provider participation to the extent necessary to meet the needs of Members. This provision also does not interfere with measures established by the Contractor to maintain quality of services or control costs consistent with its responsibilities under this Contract; nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty. If the Contractor declines to include individual or groups of providers in its network, it shall provide the affected providers written notice of the reason for the

decision. In addition, the Contractor shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 C.F.R. 438.214(c)).

(3). When selecting providers for inclusion in the network, the Contractor shall consider a potential provider's experience and expertise with children with special health care needs, children who have severe physical disabilities, and children with multiple disabilities. The Contractor shall consider providers requested by Members and their families, State agency personnel, system stakeholders and providers frequently used for Out-of-Network services. The providers shall meet the minimum Credentialing qualifications, licensing and certification requirements in this Contract, AHCCCS AMPM Policies 610 and 950 and in the CPPM, Chapter 12.0.

(4). When making a decision about the retention of a provider in the network, the Contractor shall consider the number of providers available with similar expertise, the provider's experience, Provider Quality Data, geographic location, cultural and linguistic factors and/or unique delivery considerations, and any concerns voiced by State agency personnel and system stakeholders. The Contractor shall clearly describe and disseminate the policies, procedures and criteria to be used for termination of a provider from the Contractor network.

(5). In selecting providers, the Contractor shall require providers to comply with all requirements in the subcontract including requirements to: 1) obtain an active AHCCCS provider identification number and sign an AHCCCS provider Registration Agreement, 2) obtain a unique National Provider Identifier (NPI), 3) operate within the scope of their practice, and 4) obtain and maintain all applicable insurance. In accordance with the Uniform and Special Terms and Conditions, the Contractor shall obtain and keep on file copies of complete and valid provider insurance certificates for each subcontracted provider in the network and shall provide these certificates to the ADHS Procurement Office upon request.

D. Administrative Network Requirements

(1). The Contractor shall have written agreements with all providers delivering Covered Services, either in the form of single case agreements or Subcontracts. All subcontracted providers must be credentialed per 42 C.F.R. 438.206. Minimally, the Contractor shall credential and subcontract with providers who, within a Contract Year, provide services to five (5) or more Members or provide services to Members twenty-five (25) or more times. ADHS may, for good cause and at its sole discretion, waive or modify this requirement in specific instances, upon request of the Contractor, when sufficient proof of effort to subcontract with the provider is produced by the Contractor.

(2). In establishing the network, the Contractor shall consider the following:

(a). the anticipated number of Members;
(b). the expected utilization of services, considering Member characteristics such as age, gender, race/ethnicity and health care needs, including the prevalent diagnoses;
(c). the number and types (in terms of training, experience and specialization) of providers required to provide the full scope of Covered Services;
(d). network providers' capacity to accept new Members to their caseload;
(e). the geographic location of providers relative to Members, considering distance, travel time, the means of transportation used by Members and whether the facility meets the requirements of the Americans with Disabilities Act (ADA); and
(f). Provider Quality Data, including:
i. performance on Appointment Access Standards:
ii. treatment and functional outcome data;
iii. results of surveys or other qualitative review activities;
iv. numbers of valid Grievances;
v. utilization patterns;

vi. results of audits, site visits or other special reviews conducted by ADHS or the Contractor; and
vii. quality of care concerns.

E. Network Standards

The network shall be designed to meet the following standards:

(1). Appointment Access Standards

(a). When the Contractor's Medical Director or designee determines that a physical examination is needed to determine medical eligibility; it shall be scheduled within thirty (30) days of a Referral.

(b). Following Enrollment, a Member shall be seen for Medically Necessary Services in accordance with the initial Service Plan, or if not specified in the Service Plan, within forty-five (45) days.

(c). A Member with an Urgent Medical Need shall be given an appointment with a medical provider within seventy-two (72) hours of a request.

(d). A Member's waiting time for a scheduled appointment shall not exceed forty-five (45) minutes unless the provider is delayed due to an emergency.

(2). Geographic Accessibility

The Contractor's network shall provide a geographically dispersed network with convenient access to services for Members. Because pediatric sub-specialists are in short supply and concentrated in urban areas, the Contractor shall implement strategies to improve Member access to pediatric subspecialties, as well as other provider types for which there are shortages, regardless of the Member's place of residence. Access shall be no more restrictive than that available to the general population.

The Contractor's network shall include:

(a). At least two (2) MSIC sites in the Phoenix metropolitan area, at least one (1) MSIC site in the Tucson metropolitan area, at least one (1) MSIC site in the Prescott/Sedona/Flagstaff area, and at least one (1) MSIC site in the Yuma area. The Contractor shall assess the needs of its Members throughout the State and consider the efficient use of its provider resources providing MSICs at additional sites. The types of MSICs and their staffing are included in Exhibit C;

(b). Physician, pharmacy, laboratory, x-ray and therapy services available onsite at the MSIC and through a network of community-based providers closer to Members' homes;

(c). Innovative service delivery mechanisms such as Field Clinics and Virtual Clinics that incorporate the use of Telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State.

(d). At least two (2) hospitals in the metropolitan Phoenix area and at least two (2) hospitals within the Tucson metropolitan area.

(e). Community-based, family support providers in urban, suburban and rural areas of the State.

(f). Across State border, community-based providers within the United States for Members in communities where the normal pattern of receiving health care services includes the use of providers in neighboring states.

2. Network Management

A. Network management functions shall include:

(1). network design;

(2). recruitment, selection, contract negotiation and retention of providers;

(3). communication with and education of network providers;

(4). Credentialing and recredentialing of providers;

(5). completion of Subcontracts that comply with ADHS requirements;

(6). Monitoring of access to network services and provider capacity to deliver Covered Services to Members in a timely manner;

(7). Monitoring providers for compliance with subcontract requirements, this Contract and the CRSA QM Plan;

(8). report monitoring and implementing corrective action when needed;

(9). development and implementation of methods to improve, maintain and fully utilize contracted capacity of the provider network; and

(10). expansion of access to providers within the State.

B. The Contractor shall draft an annual Provider Network Plan and submit it to ADHS for review and approval. The CRS Provider Network Plan is available at: http:www.azdhs.gov/phs/ocshcn/crs_crs_rfp_documents_links.htm.

The Contractor's Provider Network Plan shall include:

(1). an assurance that the provider network is adequate and sufficient to meet the requirements of ADHS and AHCCCS;

(2). a description of the criteria used to determine the numbers and kinds of specialists that compose the provider network, including offering Members choice of providers when possible;

(3). a description of the current status of the provider network and a projection of future needs based upon, at a minimum, anticipated membership growth, the number and types (in terms of training, experience and specialization) of providers that exist in the State, as well as the number of physicians who have privileges with and practice in hospitals, the expected utilization of services, given the characteristics of the CRS population and its health care needs; the number of providers without capacity to accept new Members and the access of Members to specialty services as compared to the general population of the community;

(4). a network inventory, that lists providers by clinic, facility, provider type, name and specialization;

(5). current network gaps and the methodology used to identify them;

(6). short-term interventions to address network gaps, including expedited or temporary Credentialing;

(7). long-term interventions to fill network gaps and barriers to those interventions;

(8). network adequacy measures/evaluation of interventions;

(9). ongoing activities for network development, including those directed to recruiting providers to Arizona to expand access within the State, particularly pediatric sub-specialists. This includes the coordination and partnership with outside organizations in the expansion of the network;

(10). coordination between the Contractor's internal departments in communicating with providers, their education and Monitoring of the network;

(11). the methodology(ies) the Contractor uses to collect and analyze provider feedback about the network design and implementation; and

(12). when specific provider issues are identified, the protocols for addressing them.

C. Communication and Education of Providers

(1). The Contractor shall have written policies and procedures that address Contractor – network provider communications, including procedures for responding to provider inquiries and complaints.

(2). The Contractor shall have a website as described in the Member Services section of this RFP, with links to information such as the CRS Formulary, the CPPM, the Member Handbook, the Provider Manual, the provider network directory, Prior Authorization requirements, pertinent Contractor policies and procedures and an interactive claims status inquiry site. Hard copies of the documents shall be available to providers upon request.

The Contractor shall utilize the ADHS Provider Manual template to develop a CRS Provider Manual.

(3). The Contractor shall regularly communicate with the network, such as in a provider newsletter. The Contractor shall be responsible for dissemination of certain information to the provider network when requested by ADHS.

(4). The Contractor is required to obtain prior approval from ADHS regarding material changes to the CRS program. A Material Program Change is defined as any change in overall business operations (i.e. policy, process, protocol, etc) that could have an impact on or reasonably be foreseen to have an impact on more than five percent (5%)) of the Members and/or providers. The Contractor must request approval of a Material Program Change at least sixty (60) days prior to the expected date for implementation of the requested change. The Contractor shall notify affected Members and/or providers, in writing, of ADHS-approved

changes to the CRS Program thirty (30) calendar days prior to a change going into effect.

(5). The Contractor shall have an initial orientation in place for new providers that includes information about the CRS Program, children with special health care needs, the interdisciplinary approach to family centered, culturally competent care, care coordination, the Integrated Medical Record, Service Plans and pertinent Contractor policies and procedures.

(6). Ongoing educational opportunities will be offered to providers. Technical assistance shall be available based on provider request and/or provider performance. Educational opportunities about more general topics such as children with special health care needs, claims submission or culturally appropriate health care shall be available in a group setting or on-line. The Contractor shall maintain records of its educational activities, including the names of attendees, sign in sheets and training materials.

D. Credentialing Requirements

(1). The Contractor shall have written policies and procedures to credential and re-credential the following providers in its network:

(a). physicians (MDs, DOs, and DPMs):
(b). nurse practitioners, physicians assistants or certified nurse midwives;
(c). psychologists (PhDs, PsyDs, EdDs);
(d). ancillary and allied health professionals;
(e). dentists and affiliated dental hygienists; and
(f). other independent professionals who contract directly with the Contractor.

(2). The Contractor credentialing and recredentialing process, including provisional credentialing, shall be consistent with the AHCCCS AMPM Chapter 600 and CPPM, Chapter 12.0.

(3). When necessary to address gaps in the network or otherwise appropriate, the Contractor shall utilize processes

to expedite temporary (or provisional) credentialing to maintain network sufficiency or to add specialty providers.

E. Network Model Subcontracts

The Contractor shall include the Uniform Terms and Conditions from this Contract in its provider subcontracts. In addition, the Contractor shall include the Minimum Subcontract Provisions in Exhibit E in its provider subcontracts. Additional provider Subcontractor requirements are listed below:

(1). The Contractor shall develop and implement financing methods, including performance measures and financial incentives for inclusion in its provider subcontracts to require accurate and timely reporting of Encounter Data.

(2). The Contractor shall require all providers placed at financial risk for service delivery to comply with Federal and State rules governing incentive payments. Specifically, the Contractor Subcontracts shall require compliance with all applicable physician incentive requirements and conditions defined in 42 C.F.R. §438.6(h), 422.208 and 422.210, which prohibit physician incentive plans from directly or indirectly making payments to a physician or group as an inducement to limit or refuse Medically Necessary Services to a Member.

(3). The Contractor shall not enter into Subcontracts that place the providers at significant financial risk as defined in 42 C.F.R. §§422.208, 22.210, and 438.6(h) unless specifically approved by ADHS in advance. To obtain approval, the Contractor shall submit to ADHS ninety (90) days prior to entering into the Subcontract:

(a). a complete copy of the Subcontract,

(b). a plan to implement a Member satisfaction survey,

(c). details of the stop-loss protection provided, and

(d). a summary of the compensation arrangement that meets the substantial financial risk definition.

(4). The Contractor is required to disclose all physician incentive agreements to ADHS and to Members who request them. The Contractor shall disclose to ADHS the information on physician incentive plans contained in 42 C.F.R. §§422.208 and 422.210 in accordance with the AHCCCS Physician Incentive Plan Disclosure by Contractor's Policy upon subcontract renewal, prior to initiation of a new incentive plan agreement, or upon request of ADHS, AHCCCS, or CMS. The Contractor shall also comply with physician incentive plan requirements set forth in 42 C.F.R. §438.6(h), which apply to contract arrangements with subcontracted entities.

(5). The Contractor shall enter into written agreements with providers. Each provider shall:

(a). meet all applicable credentialing, licensing or accreditation requirements;

(b). provide Encounter information or submit Clean Claims consistent with AHCCCS requirements;

(c). actively participate in individualized treatment planning for any Member for whom the provider delivers service.

(d). actively participate in maintaining and using an Integrated Medical Record; and

(e). agree to participate in ADHS Peer Review as requested.

(6). The Contractor shall set a provider fee schedule that prescribes rates for provider services. Options for case rates and subcapitation may be included.

(7). All Subcontracts shall include the following provisions:
(a). the name and address of the Subcontractor;
(b). the method and amount of compensation, reimbursement, payment, or other considerations provided to the Subcontractor;

(c). identification of the population to be served by the Subcontractor, including the number of Members the Subcontractor is expected to serve;
(d). the amount, duration and scope of Covered Services to be provided;
(e). the term of the Subcontract, including beginning and end dates and procedures for extension, termination and renegotiation;
(f). specific Subcontractor duties relating to coordination of benefits and determination of Third-Party Liability (TPL);
(g). identification of Medicare and other TPL coverage and seeking Medicare or TPL payment before submitting claims and/or Encounters to Contractor, when applicable;
(h). maintenance of a cost record keeping system;
(i). compliance with the requirements in the CRS QM and UM Plans;
(j). a written contract amendment and prior approval of ADHS is required if the Subcontractor participates in any merger, reorganization, or change in ownership, or control that is related to or affiliated with the Contractor;
(k). obtaining and maintenance of all applicable insurance policies required in this Contract and submission of a copy of insurance certificates to the Contractor;
(l). assumption of full responsibility for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations required in this Contract, for itself and its Employees, and AHCCCS or ADHS shall have no responsibility or liability for any taxes or insurance coverage;
(m). incorporation by reference of the CPPM and a requirement that the Subcontractor complies with all requirements stated in accordance with these documents;
(n). compliance with Encounter reporting and claims submission requirements in accordance with the CPPM, including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting;

(o). the right of a Subcontractor to Appeal a Claims Dispute in accordance with the CPPM;

(p). assistance to Members in understanding their right to file Grievances and Appeals in accordance with the CPPM shall be provided by the Subcontractor;

(q). compliance by the Subcontractor with audits, inspections and reviews in accordance with the CPPM and the AHCCCS Audit Guide, including any reviews the Contractor, ADHS, or AHCCCS may conduct;

(r). cooperation of the Subcontractor with other Contractors and/or State employees in scheduling and coordinating its services with other related service providers that deliver services to Members;

(s). facilitation by the Subcontractor of another Subcontractor's reasonable opportunity to deliver services and the prohibition of any commission or condoning of any act or omission by the Subcontractor that interferes with, delays, or hinders service delivery by another Subcontractor or by State employees;

(t). timely implementation by the Subcontractor of ADHS, AHCCCS, and Contractor decisions related to a Grievance, Appeal, or Claims Dispute;

(u). compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Member;

(v). a requirement for all providers contracting directly with the Contractor, to be registered as Medicare service providers. This requirement applies only to providers that have a valid Medicare provider type and deliver services paid by Medicare;

(w). the Subcontractor shall not bill, balance-bill, or charge Members for services if the Contractor becomes insolvent, or ADHS or the Contractor do not reimburse the provider;

(x). when applicable, Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers;

(y). the definition of medical necessity; and

(z). incorporate by reference the terms and conditions of this Contract.

(8). The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Specifically, the Contractor shall not contract with a provider and require that the provider not provide services for another Contractor. In addition, except for cost-sharing requirements, the Contractor shall not enter into written agreements that contain compensation terms that differ depending upon a Member's funding source.

(9). Network providers shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to other Medicaid and public program enrollees, if the provider serves only Medicaid and public program enrollees.

F. Monitoring Adequacy and Sufficiency of Network

(1). The Contractor's provider network shall meet all requirements of this Contract. At a minimum, the Contractor shall measure the appointment availability for providers using a primary verification methodology, rather than relying on self-reported data from providers. In addition, the Contractor shall establish mechanisms to ensure that network providers comply with the timely access requirements; monitor regularly to determine compliance; and take corrective action if there is a failure to comply. (42 C.F.R. 438.206(c)(1)(iv), (v), and (vi).

(2). In addition, the Contractor shall monitor network adequacy through tracking and trending of requests for authorization for Out-of-Network provider visits and identification of trends in Member and provider Grievances concerning the network.

G. Monitoring Delivery of Services by Providers

(1). The Contractor shall monitor the QOC, Cultural and Linguistic Competency of providers and incorporation of Family-Centered Care (FCC) into the delivery of services.

(2). The Contractor shall have written policies and procedures to insure that information regarding provider performance is communicated to the staff responsible for Monitoring and assessing provider performance, regardless of the point-of-entry of the performance feedback within the Contractor's operations.

H. Network Capacity

The Contractor shall implement methodologies to maintain, improve and fully utilize its network capacity. Methodologies include, but are not limited to:

(1). implementing Field Clinics and Virtual Clinics;

(2). using Telemedicine, incorporating up-to-date technology;

(3). partnering with community organizations to recruit providers to Arizona and into the network;

(4). partnering and collaborating with AHCCCS Contractors regarding transportation to appointments within the Contractor's network that become available in less than seventy-two (72) hours; and

(5). providing support to providers in the use of innovative strategies to increase their capacity for Members.

3. Network Deliverables

The Contractor shall provide the network reports and other deliverables to ADHS as described in Exhibit B including:

A. Annual Provider Network Plan

At the time the Contractor enters into the contract with ADHS and annually thereafter, the Contractor shall submit to ADHS the written Annual Provider Network Plan in accordance with Exhibit B of this Contract signed by the Contractor's Chief Executive Officer, affirming that the provider network is adequate and sufficient to

meet the requirements of this Contract. The assurance shall confirm that the network:

(1). offers a full array of Covered Services to meet the needs of the anticipated number of Title XIX and Title XXI Members and Non-Title XIX and Non-Title XXI Members;

(2). maintains providers in sufficient number, mix, and geographic distribution to meet the accessibility and service needs of the anticipated number of Title XIX and Title XXI Potential Members and Members and Non-Title XIX Applicants and Members; and

(3). meets all specified requirements of the Contract.

B. Unexpected Network Changes

The Contractor shall notify ADHS in writing within one (1) Business Day of any unexpected changes to its provider network in compliance with the CPPM, Chapter 14.0.

C. Notification Requirements for Material Changes to the Network

The Contractor shall notify and obtain written approval from ADHS, in accordance with the CPPM, Chapter 14.0, at least sixty (60) days in advance of making any Material Change to the size, scope or configuration of the network. A Material Change is defined as any change in overall business practice that could have an impact on five percent (5%) or more of the recipients, providers, or AHCCCS programs, or a change that may significantly impact the delivery of services provided by the Contractor. A Material Change in the Contractor's network requires thirty (30) days advance written notice to affected Members.

D. Quarterly Network Status Reports

The Contractor shall submit written Quarterly Network Status reports in a format approved by ADHS and according to the schedule in Exhibit B.

The Contractor' Quarterly Network Status reports shall include separate sections reporting changes by providers (organized by provider type) and Clinics. Each section shall include the following elements for providers lost and gained: the name and address of each provider, provider type, contracted capacity, AHCCCS provider identification number, populations served and an analysis of the effect on network sufficiency.

If a provider loss results in a material gap or network deficiency, within thirty (30) days the Contractor shall submit to ADHS a plan with timeframes and action steps for correcting the gap or deficiency. The plan shall address the transition of Members to appropriate alternative service providers in accordance with the network notification requirements. As part of the Quarterly Network Status reports, the Contractor shall report progress in accordance with the Annual Provider Network Plan to increase service capacity in areas requiring further development, including barriers encountered and actions planned to eliminate the barriers.

E. The Out-of-Network Services Report.

The Contractor shall submit a report on Out-of-Network services on a quarterly basis. The report shall identify the Member, the Member's CRS Diagnosis, the Out-of-Network provider(s) that provided Covered Services, the dates of service and the Covered Services provided, provider claim status and a copy of the agreement between the Contractor and the Out-of-Network provider.

E. ADMINISTRATION

The Contractor shall collaborate with ADHS to develop and maintain effective and efficient administrative operations that contribute to the delivery of timely, accessible and effective services as demonstrated through improved outcomes and Member satisfaction. The Contractor shall identify issues and implement problem solving strategies utilizing a proactive approach based on the Contractor's experience and expertise. The Contractor shall include the following elements in its proactive approach:

- issue identification, corrective action planning, execution, outcome monitoring and reporting;
- effective time management, including sufficient autonomy at the local level to allow for timely management decisions;

- data-driven decision-making;
- accurate, complete, and timely data analysis and reporting;
- sufficient numbers of appropriately qualified and trained staff members;
- effective human resource management;
- a demonstrated commitment to continuous QI;
- communications management;
- risk identification, analysis, and response planning, documentation, communication, and mitigation;
- contract management and compliance; and
- compliance with all applicable regulatory requirements (Federal and State), policies, standards, guidelines, and procedures.

The Contractor shall comply with administrative requirements as described in this Contract and all documents incorporated by reference, Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall develop, implement, and monitor compliance with written policies and procedures that conform to the administrative requirements identified in the CPPM and this Contract.

1. Organizational Structure and Staffing

   The Contractor shall have organization, management and administrative systems capable of meeting all Contract requirements. The Contractor shall maintain a significant and sufficient local presence (within Arizona) and a positive public image.

   If the Contractor maintains its corporate headquarters based in a location other than Arizona:
   - the Contractor's corporate CEO/President and members of its leadership team shall travel to Arizona, to meet with ADHS as required by ADHS; and
   - the Contractor's corporate CEO/President shall provide the Contractor's Arizona-based management team with the authority, autonomy, resources and responsibility necessary to administer this Contract.

   After Contract award, the Contractor shall obtain written approval from ADHS prior to delegating any required activity or moving administrative or Managed Care functions outside Arizona. The Contractor's request for approval shall include a description of the Contractor's processes in place to ensure rapid responsiveness to ADHS's concerns regarding Contract

compliance. The Contractor shall pay for any additional costs incurred by ADHS associated with on-site audits or other oversight activities that result when required systems are located outside of the State.

A. General Personnel Requirements

(1). The Contractor's organizational structure shall be of sufficient size and scope to efficiently and effectively manage the delivery system, to demonstrate continued improvement of service delivery and treatment outcomes. The Contractor's organization shall be designed to readily adapt to the changing needs of Members and their families and ensure that all Members have access to needed Covered Services.

(2). The Contractor's organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various components and departments of the organization and be easily understood and accessible by those interfacing with it.

(3). The Contractor shall have a sufficient number of qualified staff with necessary experience and expertise to provide clerical and administrative support and facilitate the effectiveness of the Contractor's operations. The Contractor shall have a sufficient number of qualified human resources staff with the necessary experience and expertise to conduct ongoing hiring and recruitment to keep pace with personnel needs and to ensure personnel disputes are handled fairly and quickly to avoid an unnecessary, negative impact on morale.

(4). The Contractor shall require that all staff have the training, education, experience, orientation, and Credentialing, as applicable, to perform assigned job duties. The Contractor shall maintain current organization charts and written job descriptions for each functional area consistent in format and style.

(5). The Contractor shall not employ or subcontract with any individual or company that has been debarred, suspended,

or otherwise lawfully prohibited from participating in any public procurement activities or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 and 42 C.F.R. §438.610(a) and (b).

B. Key Personnel.

The Contractor shall provide adequate experienced personnel, capable of and devoted to the successful accomplishment of work to be performed under this Contract. The Contractor shall employ one full time individual for each of the following Key Personnel to work full time in Arizona:

(1). Chief Executive Officer (CEO): who resides in Arizona and has full-time and ultimate responsibility for the management of the Contract operations and compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The CEO shall have experience and expertise applicable to this position and its responsibilities.

(2). Chief Medical Officer (CMO or Medical Director): an Arizona-licensed physician, board-certified in pediatrics or a pediatric sub-specialty, who resides in Arizona and has full-time responsibility for the effective implementation of all clinical-medical programs, the QM and UM programs in compliance with Federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The CMO shall have experience and expertise applicable to this position and its responsibilities. Additionally, the CMO shall be involved in:

(a). development, implementation, and interpretation of medical policies and procedures;
(b). physician recruitment to carry out the Contractor's functions and requirements;
(c). review of professionals' network applications and submit recommendations regarding Credentialing and reappointment;
(d). provider profile design and interpretation;
(e). administration of UM and QM activities;

(f). continuous assessment and improvement of the QOC provided to Members;
(g). development and implementation of the QM and UM plans and serve as the chairperson of the Contractor's QM, UM, and Peer Review Committees with oversight of other medical/clinical committees;
(h). provider education, in-service training and orientation; and
(i). attendance at regular ADHS Medical Director meetings.

(3). Chief Financial Officer (CFO): a full-time Arizona-licensed Certified Public Accountant with experience and demonstrated success in Managed Care responsible for effective implementation and oversight of the budget, accounting systems, and all financial operations of the Contractor in compliance with Federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The CFO shall have experience and expertise applicable to this position and its responsibilities.

The Contractor shall immediately, verbally inform ADHS and provide written notice to ADHS within three (3) Business Days after the date of a resignation or termination of any of the Key Personnel listed above, including the name of the interim contact person that will be performing the CEO's, CMO's or CFO's duties.

C. Organizational Staff Members

The Contractor shall employ sufficient numbers of staff to effectively perform the following functions:

(1). QM Administration. This position shall hold one of the following designations (MD, DO, PhD, RN, LPN, or PA) and is responsible for the development of the Contractor's QM plan and its effective implementation in collaboration with the CMO and the UM Administrator. The QM Administrator shall ensure the QM program is in compliance with Federal and State laws; and the requirements in this Contract, including all documents incorporated by reference. The QM Administrator shall have significant experience and expertise

in the oversight of effective QM in public sector health care programs and Managed Care delivery systems.

(2). Utilization Management Administration. This position shall hold one of the following designations (MD, DO, PhD, RN, LPN or PA) and is responsible for assuring the UM program is in compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The UM Administrator shall have significant experience and expertise in the implementation of a UM program that ensures Members receive effective, Medically Necessary Services in a timely manner.

(3). Member Services Administration. This position is responsible for stakeholders' timely telephone access to accurate information regarding the CRS system. The Member Services Administrator ensures the appropriate triage of all calls including information inquiries, service requests, Referrals, Grievances, Appeals, Claim Disputes and QOC issues. The Member Services Administrator shall have significant experience and expertise in the management of a member service department and complaint resolution in compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference.

(4). Network Development/Management Administration. This position is responsible for assuring network adequacy and timely appointment access, development of network resources in response to unmet needs, adequacy of networks to provide Member choice of providers when feasible, contracting with providers, and compliance with Federal and State laws related to Network Development/Management and the network requirements set forth in this Contract, including all documents incorporated by reference. The Network Development/Management Administrator is also responsible for assuring timely inter-provider referrals and associated appointment access, and assisting in resolving provider complaints, disputes between providers and the triage of Grievances regarding providers. The Network Development/Management Administrator coordinates

provider site visits, reviews provider profiles and implements and monitors CAPs as needed. This individual shall have significant experience and expertise in network development, contracting, Credentialing and provider communications.

(5). Information Systems Administration. This position is responsible for oversight of the management information systems requirements, and compliance with Federal and State laws related to Information Systems and the MIS requirements in this Contract, including all documents incorporated by reference. The Information Systems Administrator shall have significant experience and expertise in data systems and is responsible for all data interfaces.

(6). Claims/Encounters Administration. This position is responsible for full-time oversight of timely and accurate claims and encounters processes. The Claims/Encounters Administrator shall have significant experience and expertise in processing claims and encounters, especially as it relates to Medicaid and Medicare requirements, including coordination of benefits. The Claims/Encounters Administrator is responsible for compliance with Federal and State laws related to claims/encounters and the claims/encounter requirements in this Contract, including all documents incorporated by reference.

(7). Grievance System Administration. This position is responsible for the timely processing of notices, Grievances, Appeals, State Fair Hearings and Claim Disputes in compliance with related Federal and State laws and requirements in this Contract, including all documents incorporated by reference. The Grievance System Administrator advocates for Member rights within the organization, assuring Grievance System trends are reported to and addressed within the QM Committee. At a minimum, the Grievance System Administrator shall be a licensed attorney, have a juris doctor degree from an accredited institution, or have earned a paralegal certificate. This individual shall have significant experience and expertise in managing a Grievance System in a Managed Care environment.

(8). Corporate Compliance Administration. This position is responsible for oversight, administration and implementation of the Contractor's Compliance Program. The Corporate Compliance Administrator is responsible for ensuring Contractor compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The Corporate Compliance Administrator coordinates the Corporate Compliance Committee, oversees all audits related to the Contract, regulatory and policy and procedure compliance and collaborates with the ADHS Fraud and Abuse program. The Corporate Compliance Administrator shall have access to all persons employed within the system and shall have designated and recognized authority to access provider records and make independent referrals to the AHCCCS Office of Program Integrity or other duly authorized enforcement agencies. The Compliance Administrator shall have significant experience and expertise in operating compliance programs. The Corporate Compliance Administrator shall report directly to the CEO.

(9). Telemedicine Coordination. This position is responsible for oversight, administration and implementation of Telemedicine services and equipment in compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The Telemedicine Coordinator ensures Telemedicine is available and utilized when appropriate to ensure geographic accessibility of services for Members. This person shall also be responsible to assist in the expansion of Telemedicine services, when appropriate. This individual shall have experience and expertise applicable to this position and its responsibilities.

(10). Cultural Sensitivity Consultation. This position is responsible for designing, implementing, and adjusting the CRS health delivery system operations to meet the Cultural needs of Members and their families. This position requires significant experience and expertise in the identification of health service delivery components and processes that value and promote health and improved quality of life in diverse cultures.

The Contractor shall submit all reports or other deliverables related to Key Personnel and staffing as described in Exhibit B.

2. Separate Corporation

Within sixty (60) days of Contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this Contract, whose sole activity is the performance of Contract functions and operations with the State (e.g., ADHS, AHCCCS, and ADES).

3. Contractor's Use of Subcontractors

A. The Contractor shall be responsible for compliance with all Contract requirements, regardless of whether the Contractor enters into a subcontract to delegate performance of the Contract Managed Care or administrative requirements or to deliver Covered Services. Prior to selecting a Subcontractor, the Contractor shall evaluate a prospective Subcontractor's ability to perform the activities to be delegated. The Contractor shall monitor and formally review a Subcontractor's performance on an ongoing basis. The Contractor shall formally review Management Services Subcontractors at least annually. The Contractor shall formally review provider Subcontractors as described in the Contractor's Network Plan, as approved by ADHS. If the Contractor identifies areas for improvement in a Subcontractor's performance, the Contractor shall require the Subcontractor to complete a CAP. The Contractor shall also have authority to revoke delegation or sanction Subcontractors for non-performance.

B. The Contractor shall not prohibit a subcontracted provider from contracting to deliver services to ADHS or AHCCCS, or to an ADHS or AHCCCS Contractor or Subcontractor. The Contractor shall require all Subcontractors to comply with applicable provisions of Federal, State and local laws, rules, regulations, standards, Executive Orders governing performance of duties under the subcontract and policies. The Contractor and its Subcontractors shall not contract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 42 C.F.R. §438.610(a) and (b). The Contractor shall

maintain at least two (2) fully executed originals of all Subcontracts, and make them available within two (2) days of ADHS's request.

C. The Contractor shall enter into a subcontract with any provider for the delivery of Covered Services except in the following circumstances:

(1). a provider that is anticipated to see less than five (5) Members or submit less than twenty-five (25) claims during the subcontract year;

(2) a provider that refuses to subcontract with the Contractor or comply with the requirements to become a Subcontractor, in which event, the Contractor shall submit documentation of the provider's refusal to ADHS within seven (7) days of its final attempt to reach an agreement; or

(3). a provider that delivers only Emergency Services.

D. The Contractor shall verify that its subcontracted providers are registered with AHCCCS and have a NPI number and are credentialed, licensed, certified and accredited in accordance with the provider qualifications contained in the CPPM and this Contract. The Contractor shall recoup Medicaid funds paid for Medicaid reimbursable Covered Services for dates of service on which the Subcontractor did not have the credentials, license, certification or accreditation required to be an AHCCCS registered provider or was not an AHCCCS registered provider.

E. The Contractor may subcontract with qualified organizations for Management Services (e.g., Managed Care administration, automated data processing or claims and/or encounter processing, credentialing verification organization) only with the prior written approval of ADHS. The Contractor shall take reasonable steps to obtain a fair price from any Management Services Subcontractor and describe the steps taken in its request to ADHS for prior written approval. The Contractor shall submit copies of all Management Services Subcontracts to ADHS at ADHS's request. Upon written request by ADHS, the Contractor shall submit a corporate cost allocation plan for the Management Services Subcontractor and proposed Management Services fee agreement. Upon written request by ADHS, the Contractor shall cooperate and comply with

an ADHS review and audit of actual management fees charged or allocations made. If ADHS determines the fees or allocations actually paid are unjustified or excessive, the Contractor shall repay the amounts and be subject to financial sanctions and corrective actions.

F. The Contractor shall include the Uniform Terms and Conditions from this Contract in its provider and Management Services subcontracts. In addition, the Contractor shall include the Minimum subcontract Provisions in Exhibit E in its provider and Management Services subcontracts. Additional Provider Subcontractor requirements are included in the Network section of the Scope of Work.

4. Business Continuity/Recovery Plan and Emergency Response

A. Business Continuity and Recovery Plan

(1). In accordance with the CPPM, Chapter 16.0, the Contractor shall develop and annually test a Business Continuity and Recovery Plan to manage unexpected events that may negatively and significantly impact its ability to serve members. The Contractor's Plan shall, at a minimum, include planning and training for:
(a). facility closure or loss of major provider(s);
(b). electronic or telephonic failure at the Contractor's main place of business;
(c). complete loss of use of the Contractor's main site;
(d). loss of primary computer system/records;
(e). Contractor's strategies to communicate with ADHS in the event of a business disruption; and
(f). periodic testing.

(2). The Contractor shall review its Business Continuity and Recovery Plan annually, update it as needed and provide it to ADHS for review by October 10, 2008 in the first Contract Year and by July 10 of each subsequent Contract Year in accordance with Exhibit B of this Contract. The Contractor shall train all Key Personnel and Organizational Staff to be familiar with the Plan.

(3). The Contractor shall require Management Services Subcontractors to prepare Business Continuity and Recovery Plans and to review their Business Continuity and Recovery Plans annually, updating them as needed. The Subcontractor plans shall, at a minimum, contain the above described terms that are applicable to the Management Services Subcontractors. This requirement does not apply to the Contractor's provider subcontracts.

B. Emergency Preparedness

(1). The Contractor shall develop an emergency response plan in case of a Presidential, State, or locally-declared disaster. The Contractor's preparedness actions shall include:

(a). development of a comprehensive disaster response plan, including specific measures for:

i. Member management and transportation;

ii. plans for access to medications for displaced Members' and

iii. plans for access to DME; and

(b). coordination with other health care contractors to assist in a disaster.

5. Reporting Requirements and Deliverables

The Contractor shall submit to ADHS the reports related to administration detailed in Exhibit B. The Contractor's submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report, and the Contractor shall be subject to a CAP, notice to cure, sanctions, and any other remedies in this Contract. The Contractor shall be subject to the following standards for determining the adequacy of required reports:

A. Timeliness.

The Contractor shall deliver reports or other required data for ADHS's receipt on or before scheduled due dates. The Contractor shall submit all required reports for ADHS receipt no later than 5:00 p.m. MST on the date due. When a due date is a Saturday, Sunday or State-recognized holiday, the due date will be the next Business Day. The Contractor shall submit to ADHS prior to the report due date a written request for extension of reporting deadlines with the reason for the request for extension and a proposed due date.

B. Accuracy.

Absent written agreement between the Contractor and ADHS, the Contractor shall prepare reports or other required data in strict conformity with authoritative sources and report specifications. By submitting reports to ADHS, the Contractor confirms that the data within the report is accurate and complete.

C. Completeness.

The Contractor shall fully disclose all required information in a manner that is both responsive and relevant to the report's purpose with no Material Omissions.

The Contractor shall be responsible for continued reporting beyond the term of the Contract. For example, processing claims and reporting encounter data will likely continue beyond the term of the Contract due to the lag time in the filing of source documents by Subcontractors.

The Contractor is responsible for submitting to ADHS during the term of this Contract the periodic reports listed and described in detail in Exhibit B.

6. Training

A. The Contractor shall ensure that all staff members have appropriate training and orientation to fulfill the requirements of his or her position. The Contractor must provide initial and ongoing staff training that includes an overview of AHCCCS and CRS Policy and Procedure Manuals; Contract requirements and State and Federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with Members or providers receive initial and ongoing training with regard to the appropriate identification and handling of QOC and service concerns. New and existing Prior Authorization and Member Services Representatives must be trained in Statewide geography and have access to mapping search engines (e.g., MapQuest, Yahoo Maps, Google Maps, etc) for the purposes of authorizing services in; recommending providers in; and transporting Members to, the most geographically appropriate locations.

B. The Contractor shall develop and implement a training program to provide the workforce with the knowledge, skill and expertise necessary to fulfill job expectations and the CRS mission. The Contractor shall monitor the effectiveness of the training program. The Contractor shall adjust training content and delivery to increase its efficacy based on feedback from participants and subsequent job performance. The Contractor shall also require its staff to participate in training provided by ADHS and AHCCCS as directed by ADHS. The Contractor shall provide training and technical assistance regarding new initiatives and Best Practices, as defined by CRS, including Practice Guidelines that affect service delivery and oversight.

C. The Contractor shall hire a sufficient number of qualified staff and allocate sufficient financial resources to maintain a comprehensive training program to enhance the knowledge and skills of all personnel and providers, and other key stakeholder groups. The Contractor's training program shall include processes to document the delivery of all trainings delivered to personnel, providers, Members and other stakeholders.

D. The Contractor shall provide orientation and on-going training to all Contractor personnel and providers in accordance with the CPPM Chapter 13.0. The Contractor shall have processes to identify the training needs of its personnel, providers, and stakeholders and provide effective trainings, orientation, and technical assistance. The Contractor's training program, as part of its routine processes, shall offer orientation and required training for providers new to the Contractor. The Contractor shall design the training program to complement the clinical and administrative supervision needs of Contractor staff.

E. The Contractor shall inform and educate community partners about the CRS Program. At a minimum, the Contractor shall perform the following training activities: develop and disseminate information regarding the availability of CRS services to providers, Health Plans, Program Contractors, and hospitals, advocacy organizations, schools, and county and State agencies.

7. Corporate Compliance

The Contractor shall have a mandatory compliance program, supported by written administrative policies and procedures designed to guard against Member and provider Fraud and Abuse. The compliance program, which shall both prevent and detect suspected Fraud or Abuse, shall include the components identified in Chapter 15.0 of the CPPM.

The Contractor shall submit a copy of their corporate compliance plan to ADHS annually.

The Contractor shall provide evidence that the compliance plan is operating (i.e., provide meeting agendas and notes, Fraud and Abuse training materials and attendance logs, False Claims Act information in their employee manuals) at the annual Administrative Review.

As stated in A.R.S. §13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or Material Omissions is guilty of a Class 2 felony.

The Contractor agrees to permit and cooperate with any on-site review or audit. A review by ADHS or AHCCCS may be conducted without notice and for the purpose of ensuring program compliance.

The Contractor shall be in compliance with 42 C.F.R. §438. 601, 42 C.F.R §438.608, and A.R.S. §36-2918.01.

When the Contractor becomes aware of suspected Fraud or Abuse, the Contractor shall immediately report this to the AHCCCS Office of Program Integrity and the ADHS Office of Program Integrity using the reporting forms provided on their respective websites.

8. Compliance Reviews

A. Annual Administrative Reviews

The Contractor shall cooperate with the ADHS on-site Annual Administrative Review of the Contractor's compliance with State and Federal requirements, program operations, fiscal operations and financial status and all programs and services required under this Contract. The Contractor shall cooperate with ADHS in

providing documents and information related to Contractor's clinical and business practices and policies, financial reporting systems, quality outcomes, timeliness, Access to Services, and any other operational or program area identified by ADHS.

ADHS has the sole discretion to determine the type and duration of the Annual Administrative Review. In preparation for the on-site review visit, the Contractor shall forward to ADHS, policies, procedures, job descriptions, Contracts, Subcontracts, logs, and any other information requested by ADHS. The Contractor shall have available on site all requested medical records and case records selected for the review. The Contractor shall make available any documents not requested in advance by ADHS, except medical records in the possession of providers, upon ADHS request during the review. The Contractor shall make available medical records in the possession of providers as soon as possible. The Contractor shall have personnel requested by ADHS available to ADHS at all times during the on-site review. The Contractor shall provide ADHS with workspace, access to a telephone, electrical outlets and privacy for conferences while on-site.

The Contractor may comment on review findings when furnished a copy of the draft Administrative Review report prior to publication of the final report. The Contractor shall implement ADHS recommendations made in the final report through a CAP to bring the Contractor into compliance with Federal, State, AHCCCS, ADHS and/or Contract requirements. The Contractor shall cooperate with any ADHS follow-up reviews or audits at any time after the Annual Administrative Review to determine the Contractor's progress in implementing recommendations and achieving program compliance.

ADHS has sole discretion to conduct administrative reviews other than the Annual Administrative Review.

B. AHCCCS Operational and Financial Reviews

The Contractor and its Subcontractors shall cooperate and comply with AHCCCS Operational and Financial Reviews, including AHCCCS audit provisions, and shall participate as required by ADHS in accordance with AHCCCS and CMS requirements for the purpose of ensuring operational and financial program compliance

for Title XIX and Title XXI programs and other reasons as required. The Contractor shall cooperate with AHCCCS or ADHS in providing documents and information related to Contractor's clinical and business practices and policies, financial reporting systems, quality outcomes, PIPs, Performance Measures, timeliness, Access to Care services, and any other operational or program area identified by AHCCCS or ADHS. The Contractor shall comply with ADHS recommendations in areas identified for improvement. The Contractor shall cooperate with AHCCCS or ADHS in monitoring the Contractor's progress toward implementing mandated programs and CAPs.

C. External Quality Review Organization (EQRO) Reviews

The Contractor and its Subcontractors shall cooperate with AHCCCS and ADHS in any annual, external, independent review performed by an EQRO of quality outcomes, timeliness of and access to the services upon ADHS's request.

9. Corrective Action, Sanctions, Notice to Cure, and Contractor Claims Disputes

A. Corrective Action Plans

Contractor shall implement corrective action when it is determined that the Contractor has not fulfilled its obligations under this Contract. The need for corrective action may be identified through various means including but not limited to, Grievance and Appeals; QM information; problem resolution; financial information; administrative reviews; or information obtained in any Contract deliverable or investigation.

If required, the Contractor shall develop a written CAP using a format prescribed by ADHS. A CAP shall be the means of communication between the Contractor and ADHS regarding resolution of the identified issue.

B. Sanctions

ADHS may impose financial sanctions for failure to comply with the terms of this Contract or requirements set forth in the documents incorporated by reference, including a failure to comply with a CAP.

Sanctions shall be assessed according to the severity of the violation.

(1). Unless explicitly stated otherwise in this Contract, at the discretion of ADHS, sanctions shall be applied as follows:

(a). Non-compliance with a Contract requirement by the Contractor that has an extreme negative impact on the service delivery system or that causes or results in extreme harm to a member shall result in a severe financial sanction ranging from $2,000 to $100,000;

(b). Non-compliance with a Contract requirement by the Contractor that has a significant negative impact on the service delivery system or that causes or results in significant harm to a member shall result in an intermediate financial sanction ranging from $1,000 to $50,000;

(c). Non-compliance with a Contract requirement by the Contractor that has a negative impact on the service delivery system or that causes or results in harm to a Member shall result in a minor financial sanction ranging from $500 to $25,000; and

(d). Non-compliance with any Contract term may result in a financial sanction ranging from $500 to $10,000.

ADHS shall determine, at its sole discretion, the amount of the sanction. ADHS shall provide written notice to the Contractor specifying the sanction, the grounds for the sanction, identification of any subcontracted providers involved in the violation, the amount of funds to be withheld from payments to Contractor and the steps necessary to avoid future sanctions.

(2). The Contractor shall complete all steps necessary to correct the violation and to avoid future sanctions or corrective actions within the timeframe established by ADHS in the notice of sanction. Following the notice of sanction, the full sanction amount shall be withheld from the next monthly payment. If the Contractor does not correct the violation

within the timeframes established in the notice of sanction, ADHS may impose an additional penalty, which at the discretion of ADHS, may be equal to or greater than the penalty for the first violation multiplied by one (1) plus the number of additional months (or portion of a month) during which the violation continues.

If Contractor is found by ADHS to have violated the same Contract provision on two or more occasions within a two (2) year period, then ADHS, at its discretion, may increase the amount of the first month's penalty by an amount not to exceed the amount of the penalty for the first violation multiplied by (one (1) plus the number of repeat violations).

For example: assume Contractor violates a Contract provision for which the first month's penalty is $5,000. If a second violation of the same provision occurs within two (2) years of the first violation, the penalty for the first month of the second violation could be as high as $10,000. If a third violation of the same provision occurs within two (2) years of the first violation, the penalty for the first month of the third violation could be as high as $15,000.

ADHS shall offset against any payments due Contractor until the full sanction amount is paid.

(3). AHCCCS Imposed Sanctions

If AHCCCS, pursuant to the IGA with ADHS or AHCCCS regulations, imposes a sanction against ADHS for any act or omission that the Contractor was prohibited from or required to perform under this Contract, the Contractor shall be responsible for payment in an amount equal to the amount of the sanction imposed by AHCCCS against ADHS. If the sanction from AHCCCS is based on an act or omission that is the obligation of more than one Contractor, the Contractor shall be responsible for payment according to ADHS's allocation of the sanctions to the Contractor that accounts for the Contractor's share of responsibility.

The Contractor shall be responsible for payment of any financial sanctions imposed on ADHS by AHCCCS related to

the Contractor's performance under this Contract. The Contractor's payment shall not be due until AHCCCS has imposed sanctions upon ADHS for acts or omissions related to the Contractor's performance under this Contract. If AHCCCS imposes sanctions upon ADHS, the Contractor shall either reimburse ADHS upon demand, or ADHS shall withhold payment of any sanction, disallowance amount, or amount determined by AHCCCS to be unallowable, after exhaustion of the Appeals process, when applicable, and provided the Federal government does not impose the sanctions until after the Appeals process is completed. The Contractor shall bear the administrative cost of the Appeals process.

(4). Any recoupments imposed by the federal government and passed through to the Contractor shall be reimbursed to ADHS upon demand.

(5). The Contractor may file an Appeal to any sanctions imposed by ADHS in accordance with the processes outlined in the CPPM, Chapter 7.0.

C. Notice To Cure and Contract Termination

Prior to imposition of Contract termination as a sanction for non-compliance, ADHS may provide the Contractor a written Notice To Cure regarding the details of the non-compliance. The Notice To Cure will specify the period of time during which the Contractor must bring its performance back into compliance with Contract requirements. If, at the end of the specified time period, ADHS determines that the Contractor has complied with the Notice To Cure requirements, ADHS may take no further action with respect to Contract termination. If, however, ADHS has determined that the Contractor has not complied with the cure notice requirements, ADHS may proceed with Contract termination or any other remedies as provided by law or equity, whether or not specified in this Contract.

D. Contractor Claim Disputes

The Contractor may dispute any sanction imposed by ADHS in accordance with the processes outlined in the CPPM, Chapter 7.0.

F. MANAGEMENT INFORMATION SYSTEMS

1. Overview

The Contractor shall develop and maintain a Management Information System (MIS) that collects, analyzes, integrates, and reports data. At a minimum, the MIS shall collect, track, and report information related to: Service Plans, service utilization (i.e., claims and encounters), Eligibility and Enrollment, Claim Disputes, Grievances, Appeals, and State Fair Hearings, QM, UM, Member Services, provider network management and financial operations and meet ADHS data processing and interface requirements in accordance with this Contract and in the documents incorporated by reference including the: Children's Rehabilitative Services (CRS) File Layout and Specification Manual, the Office of Program Support Operations and Procedures Manual, the CPPM, the Office of Grievances and Appeals Database Manual, and the Financial Reporting Guide. When the Contractor utilizes electronic transactions, the Contractor shall do so in compliance with HIPAA.

The Contractor shall have a sufficient number of qualified MIS with the required experience and expertise to support the maintenance and operations of the MIS for this Contract including data analysts to collect, analyze and ensure the accuracy of encounter data and other information regarding Contractor's performance. The Contractor shall also have a sufficient number of claims processing staff with the required experience and expertise to ensure the timely, accurate, and complete processing of claims, resubmissions of claims that were not initially accepted by the Contractor, and overall claim adjudication. These personnel shall have MIS and claims/encounter technical knowledge, including knowledge regarding payment rules and regulations for health care delivery systems.

The Contractor shall obtain data from providers and ensure the data are timely, accurate, and complete by, at a minimum, 1) verifying the accuracy and timeliness of reported data, and 2) screening the data for completeness, logic, and consistency.

The Contractor's MIS or any component therein is subject to ADHS approval if there are reasonable concerns regarding its suitability or ability to comply with the requirements of this Contract. The Contractor shall make available all components of its MIS system for review or audit upon request by ADHS.

When changing or making Major Upgrades to the MIS affecting claims processing, or any other major business activity, the Contractor shall provide ADHS with a MIS change plan that includes a time line, milestones, and adequate testing before implementation. At least six (6) months before the anticipated implementation date, the Contractor shall provide the system change plan to ADHS for review, comment and approval.

The Contractor shall obtain ADHS approval on the details of planned system changes, system enhancements, or software, hardware, or network procurement, including the estimated impact upon the interface process before the Contractor proceeds with the system change.

If the Contractor plans to make any modifications that may affect any of the data interfaces, it shall first provide ADHS the details of the planned changes, the estimated impact upon the interface process, and unit and parallel test files. The Contractor shall not implement the proposed change until ADHS evaluates and approves the test data. The Contractor shall notify ADHS in advance of the exact proposed implementation date of all changes and cooperate with ADHS if ADHS elects to monitor for unintended impacts of the change.

The Contractor shall implement changes in their MIS to accommodate ADHS file format, layout, and process changes with ninety (90) days prior notice from ADHS.

2. Claims Payment Encounter Reporting

The Contractor shall develop and maintain a claims payment system capable of processing, cost-avoiding and paying claims in accordance with requirements outlined in this Contract, Federal regulations, and State law. The Contractor shall pay ninety percent (90%) of all Clean Claims within thirty (30) days of receipt of the Clean Claim and ninety-nine percent (99%) shall be paid within sixty (60) days of receipt of the Clean Claim. The receipt date of the claim is the date stamp on the claim. The paid date of the claim is the date on the check or other form of payment. Claims submission deadlines shall be calculated from the date of service or the effective date of eligibility posting, whichever is later. The Contractor must submit electronic Coordination of Benefits 835 transactions in accordance with HIPAA requirements. When sending remittance advices along with payment to providers, the Contractor shall include, at minimum,

adequate descriptions of all denials and adjustments, the reasons for the denials and adjustments, the amount billed, the amount paid, and provider Appeal rights for a Claims Dispute.

For each covered service delivered to a Member, the Contractor shall require providers to submit claims or encounters in accordance with claims and encounter submission requirements in the CRS File Layout and Specification Manual, the Office of Program Support Operations and Procedures Manual, CPPM, and HIPAA. The Contractor shall incorporate any future changes in the Financial Reporting Guide related to claims and encounter submission requirements. The Contractor shall require and ensure subcontracted providers to obtain a NPI.

A. Electronic Data Exchange

The Contractor shall have a MIS capable of sending and receiving information to and from ADHS and capable of receiving claims/encounter information from providers. The Contractor's MIS shall be capable of sending and receiving information to and from other agencies as identified in the, IGAs, ISAs or other contracts. At a minimum, the Contractor shall have a T1 line. The Contractor shall develop and maintain security precautions for email transmission in accordance with HIPAA and consistent with ADHS's systems and encryption methods.

B. Encounter Submissions

The Contractor shall submit encounters to ADHS in accordance with the CRS File Layout and Specification Manual, the Office of Program Support Operations and Procedures Manual, and the CPPM. The Contractor shall incorporate any future changes in the Financial Reporting Guide related to encounter submission requirements. The Contractor shall meet all timeliness, accuracy, and completeness data requirements for processing encounters in accordance with the Office of Program Support Operations and Procedures Manual. The Contractor shall be subject to sanctions for non-compliance with encounter submission standards.

The Contractor shall develop and implement policies and procedures that instruct staff to: 1) process encounters in a timely manner for accuracy and completeness; 2) ensure encounters represent the services provided and are accurately adjudicated

according to AHCCCS or ADHS standards; and 3) comply with all State and Federal requirements. The Contractor shall cooperate with ADHS when ADHS elects to monitor the Contractor's encounters for accuracy and adjudication accuracy against the Contractor's internal criteria.

The Contractor shall develop and maintain a system for monitoring and reporting the completeness of encounters and encounter data received from any subcapitated provider or providers not otherwise paid on a fee-for-service basis (e.g., hourly/daily rates). The Contractor shall verify that providers are not submitting encounters for services that were not delivered.

The Contractor shall monitor encounters received from providers on a monthly basis. At a minimum, the Contractor shall compare encounter production to monthly revenue distributed to providers (after sufficient time for claims lag). The Contractor shall have procedures in place to respond in a timely manner to material over or under production of encounters by providers.

If the Contractor delivers services directly, the Contractor shall monitor encounter production and compare the production to expenses incurred. The Contractor shall monitor encounter production by service delivery site and have procedures in place to respond to anomalies. For services delivered directly by the Contractor, the Contractor shall use statistically sound methods that are based on actual costs to develop unit values reported for these encounters. Unit values shall reasonably align with general market conditions.

With each encounter data submission, the Contractor's CEO or CFO shall submit a written attestation that based on his or her best knowledge, information and belief, the encounter data are accurate, complete and truthful.

C. Enrollment Data Submission

The Contractor shall submit Enrollment data in accordance with the CRS File Layout and Specification Manual, the Office of Program Support Operations and Procedures Manual and the CPPM. The Contractor is subject to sanctions for non-compliance with Enrollment data submission standards.

With each enrollment data submission, the Contractor's CEO or CFO shall submit a written attestation that based on his or her best knowledge, information and belief, the enrollment data are accurate, complete and truthful.

D. Appeals, State Fair Hearing and Claim Dispute Data Submission

The Contractor shall enter Grievances, Appeals, State Fair Hearing and Claim Dispute information into the Office of Grievances and Appeals database in accordance with Office of Grievances and Appeals Database Manual. The Contractor shall make initial and updated entries in the Office of Grievances and Appeals database within three (3) days of an event requiring entry.

E. Quality of Care (Grievance) Database

The Contractor shall enter QOC and non-QOC information into the database required by ADHS in accordance with CPPM Chapter 12.0 and database specifications.

F. Eligibility Inquiries

The Contractor shall utilize the AHCCCS Prepaid Medical Management Information System (PMMIS) to determine Title XIX and Title XXI eligibility and AHCCCS Health Plan/Program Contractor enrollment information. The Contractor shall identify staff that will utilize the PMMIS system and obtain log-on clearance by contacting the Office of Program Support (OPS). The Contractor shall accept OPS's technical assistance and training regarding the use and interpretation of the PMMIS data screens.

G. AHCCCS Eligibility Status Reports

The Contractor shall accept electronic data from ADHS regarding the status of Members' AHCCCS eligibility in accordance with the CRS File Layout and Specification Manual.

H. Ad Hoc Electronic Data Requests

The Contractor shall comply with any ad hoc electronic data submission, processing or review requests from ADHS upon at

least a thirty (30) day notification from ADHS unless ADHS determines the data are immediately required and vital to operate the service delivery system.

I. Contractor User Registration and Access to ADHS and AHCCCS Systems

The Contractor shall identify staff that will utilize the PMMIS system, the Grievance and Appeals database, the CRS Data Screens, and the ADHS FTP Server. Identified staff shall obtain log-on clearance by contacting and requesting such through the OPS in accordance with the Office of Program Support Operations and Procedures Manual.

J. AHCCCS and ADHS Encounter Data Validation Study (EDVS)

The Contractor and its Subcontractors shall cooperate with and participate in the required annual CMS data validation study conducted by AHCCCS and other validation studies as directed by ADHS. Upon request, the Contractor and/or its subcontracted providers shall provide any and all Covered Services data for validation as part of the studies.

Per CMS requirement, AHCCCS conducts encounter data validation studies. The Contractor shall be notified in writing of any significant change in study methodology if AHCCCS revises the study methodology, timeliness, and sanction amounts based on its review or as a result of consultations with CMS.

If AHCCCS pursuant to its IGA with ADHS or AHCCCS regulations, imposes a sanction against ADHS for any act or omission that the Contractor was prohibited or required to perform under this Contract, the Contractor shall be responsible for payment in an amount equal to the amount of the sanction imposed by AHCCCS against ADHS. The Contractor shall be responsible for all sanctions imposed against ADHS by AHCCCS as a result of data validation studies. ADHS shall notify the Contractor in writing of the sanction amounts, if applicable.

The Contractor shall conduct encounter data validation studies of its Subcontractors at least on a quarterly basis. In conducting its encounter data validation studies, the Contractor shall verify that all

services delivered to Members are being reported to the Contractor accurately, timely and are documented in the medical record. The Contractor shall conduct targeted encounter data validation studies of its Subcontractors that are not in compliance with ADHS's or the Contractor's encounter submission requirements. The Contractor shall document the results of encounter data validation studies of its Subcontractors and provide the findings to ADHS upon request.

3. Coordination of Benefits and Third-Party Liability

The Contractor shall comply with the coordination of benefits and TPL requirements in accordance with the CPPM including the two (2) methods used in coordination of benefits: cost avoidance and post-payment recovery.

The Contractor shall determine the liability of third parties that are obligated to pay for Covered Services. The Contractor shall cost-avoid a claim if it determines there is probable cause or has information that TPL exists. The Contractor shall process all claims when it determines there is no probable cause or has no information that TPL exists at the time the claim is filed.

For any AHCCCS enrolled Member or Member eligible for State Assistance at zero percent (0 %) payment responsibility, the Contractor shall pay any Co-payment, coinsurance or Deductible if a third-party payer requires the Member to pay these costs even for Covered Services delivered by an Out-of-Network provider. The Contractor shall not pay a copayment, co-insurance, or Deductible that exceeds an amount the Contractor would have paid for the entire service under a written contract with the provider delivering the service, or the AHCCCS fee-for-service payment equivalent. The Contractor shall decide whether it is more cost-effective to provide the service within its network or pay a copayment, co-insurance, or Deductible for a service outside its network. If the Contractor refers the Member for services to a third-party payer, and the payer requires payment in advance of all copayments, co-insurance, or Deductibles, the Contractor shall make the payments in advance. The Contractor shall comply with Medicare cost sharing requirements in accordance with Chapter 7.0 of the CPPM and Chapter 200 of the ACOM.

When the Contractor knows that the third-party payer will not pay a claim for a covered service because of untimely claim filing or denial of coverage, the Contractor shall not deny service delivery, deny payment of

the claim based on TPL, or require the third-party payer to send a written denial letter if the covered service is medically necessary. The Contractor shall communicate TPL information of any known change in or addition to health insurance information, including Medicare, to AHCCCS, Division of Member Services, not later than ten (10) days from the date of discovery using the AHCCCS Approved Third-Party Change Correspondence in the CPPM. If the Contractor is aware of a potential third-party payer, but does not know whether the third-party payer is liable for a particular medically necessary covered service, the Contractor shall contact the third-party payer to determine whether the third-party payer is liable to pay for the service and shall not require the Member to contact the third-party payer for this purpose. The Contractor shall deliver all medically necessary Covered Services in a timely manner when the Contractor determines a third-party payer is not liable to pay for services.

4. Post-Payment Recoveries

A. The Contractor may engage in post-payment recovery in cases where the Contractor was not aware of TPL coverage or was unable to cost-avoid at the time services were delivered or at the time they were paid.

B. The Contractor may retain up to one hundred percent (100%) of its third-party collections if all of the following conditions exist:
   (1). total collections received do not exceed the total amount of the Contractor's financial liability for the Member;
   (2). no payments are made by AHCCCS related to fee-for-service, Reinsurance, or Administrative Costs; and
   (3). the recovery is not prohibited by Federal or State law.

C. The Contractor shall report to ADHS, upon request, case level detail of third-party collections and cost avoidance including number of referrals on total plan cases.

5. Medicare Services and Cost-Sharing

The Contractor shall pay for Medicare cost-sharing expenses for Covered Services delivered to Members that are eligible for both Medicaid (Title XIX) and Medicare reimbursed services ("Dual Eligibles"). The Contractor shall comply with the different cost-sharing responsibilities that apply to Dual Eligible Members based on a variety of factors in accordance with the AHCCCS Medicare Cost Sharing Policy in the ACOM Chapter 200.

The Contractor shall not pay Medicare cost sharing expenses if the Medicare payment exceeds what ADHS would have paid for the same service delivered to a Member that is not eligible for Medicare.

The Contractor shall coordinate Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MAPDs) to Medicare Eligible Members, including Dual Eligibles. The Contractor shall base prescription drug coverage for Medicare Eligible Members enrolled in Part D on the Part D Plans' formularies.

6. Billing and Collection of Fees from Members

The Contractor shall act in accordance with the CPPM regarding collection of fees from Members. Except as provided in Federal and State laws and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS Eligible without first verifying the person was ineligible for AHCCCS on the date of service, or that the services delivered were not Covered Services.

7. MIS Reporting and Deliverables

The Contractor shall submit to ADHS all MIS-related deliverables as described in Exhibit B.

G. FINANCIAL MANAGEMENT AND PRACTICES

1. Finance and Reimbursement

A. Financial Management and Reporting

(1). The Contractor shall have a sufficient number of qualified professional staff to develop and maintain internal controls and systems to account for both CRS-related revenue and expenses and non-CRS-related revenue and expenses by type and program. The Contractor shall develop and maintain internal controls to prevent and detect fraud.

(2). The Contractor shall submit to ADHS ad hoc, monthly, quarterly and annual financial reports in accordance with the

Financial Reporting Guide and Exhibit B of this Contract. The Contractor shall prepare financial reports in accordance with Generally Accepted Accounting Principles (GAAP) in electronic and hard copy form. Where specific guidance is not found in authoritative literature or where multiple acceptable methods to record accounting transactions are available, the Contractor shall, when directed by ADHS, comply with the requirements in accordance with the Financial Reporting Guide. Upon ADHS request, the Contractor shall provide clarification in financial reports or for accounting issues identified by ADHS.

(3). The Contractor shall submit to ADHS annual financial reports in accordance with Generally Accepted Auditing Standards (GAAS) audited by an independent Certified Public Accountant.

B. Financial Viability Standards

(1). The Contractor shall separately account for all funds received under this Contract in accordance with the requirements in the Financial Reporting Guide. The Contractor shall meet all financial viability criteria.

(2). The Contractor shall comply with ADHS's established financial viability standards/performance guidelines and cooperate with ADHS's reviews of the ratios and financial viability standards listed below. The Contractor shall incorporate any future changes in the Financial Reporting Guide related to the financial viability criteria, financial ratios and standards. Failure to maintain the following ratios and financial viability standards will be considered a breach of this Contract:

(a). Defensive Interval: Must be greater than or equal to thirty (30) days.
Defensive Interval = (Cash + Cash Equivalents) divided by
((Operating Expense – Non-Cash Expense)/(Period Being Measured in Days))

(b). Equity per enrolled person: Must be greater than or equal to three hundred dollars ($300) per enrolled person on the first day of the month.

(c). Current Ratio: Current assets divided by current liabilities must be greater than or equal to 1.00.

(3). The Contractor shall enact measures to minimize against the risk of insolvency so that AHCCCS enrollees will not be liable for the Contractor's debts if the Contractor becomes insolvent. The Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge, despite insolvency.

C. Other Financial Performance Standards

(1). The Contractor shall cooperate with ADHS's due diligence in analyzing the Contractor's financial statement, monitoring financial performance standards related to the Contractor's administrative expense percentage, and service expense percentage in accordance with the standards in the Financial Reporting Guide. The Contractor shall comply with ADHS's revisions or modifications to the standards. The standards are as follows:

(2). Administrative Cost Percentage:

(a). Total Title XIX and Title XXI Administrative Costs divided by total Title XIX and Title XXI Revenue shall be less than or equal to twelve percent (12%).

(b). Total non-Title XIX and Non-Title XXI Administrative Costs divided by total Non-Title XXI and Non-Title XXI revenue shall be less than or equal to twelve percent (12%).

D. Advancement of Funds to Providers

The Contractor may advance funds to subcontracted providers to maintain the delivery of essential Covered Services to Members only with prior ADHS approval. The Contractor shall obtain prior approval of ADHS to make any advances to a Related Party or Subcontractor, make any distribution, loan, or loan guarantee to any entity including another fund or line of business within the Contractor's organization, or make any investments, other than investments in U.S. Government securities or Certificates of Deposit issued by a bank insured by the FDIC or SAIF.

E. Management of Non-Title XIX and Non-Title XXI Funding

The Contractor shall prudently manage limited Non-Title XIX and Non-Title XXI funds to continuously deliver services throughout the entire Contract Year.

2. Contractor's Payments

A. Title XIX and Title XXI Payments

The method of compensation to the Contractor for Title XIX and Title XXI Members will be prospective and retroactive capitation, Reinsurance and Third-Party Liability, as described and defined within this Contract and appropriate laws, regulations or policies. Capitation rates awarded with the Contract will be effective for the period October 1, 2008 through September 30, 2009.

(1). Capitation: Each Member has an enrollment Diagnosis that is classified into one of thirteen (13) disease classifications used by ADHS. Each of the thirteen (13) disease classifications have been identified as High, Medium, or Low risk, which is translated into the High, Medium, or Low capitation rates. The allocation of which enrolling Diagnosis groups are assigned to the High, Medium, and Low risk groups may change annually, based on updated analysis. Any such change would be accomplished in a cost-neutral manner. Each month the Contractor(s) will be paid either a High, Medium or Low capitation rate based on each Member's enrollment Diagnosis and its related classification as High, Medium, or Low. Capitation payments represent the applicable capitation rate multiplied by the member month or portion of a member month for the AHCCCS population. Member months are calculated for concurrent CRS eligible days and AHCCCS eligible days using the prior month's CRS eligibility. Retroactive member months are paid for changes in AHCCCS eligibility for the six (6) months prior to the current month. Capitation payments are inclusive of payment for medical costs (i.e., the provision of medically necessary covered services) as well as Contractor Administrative Costs and Profit/Risk/Contingencies.

(2). Reinsurance: Reinsurance is a stop-loss program provided by ADHS to the Contractor for the partial reimbursement of certain Covered Services, as described below, for a Title XIX or Title XXI Eligible CRS Member with an acute medical condition beyond an annual Deductible level. ADHS "self-insures" the Reinsurance program through a deduction to capitation rates that is intended to be budget neutral.

(a). Inpatient Reinsurance: Inpatient Reinsurance covers partial reimbursement of covered inpatient facility medical services. See the table below for applicable Deductible levels and co-insurance percentages. The co-insurance percent is the rate at which ADHS will reimburse the Contractor for covered inpatient services incurred above the Deductible. The Deductible is the responsibility of the Contractor.

The following table represents Deductible and co-insurance levels for October 1, 2008 through September 30, 2009:

Annual Deductible	**Co-insurance Percentage**
$50,000	75 %

Beginning October 1, 2009, and annually thereafter, each of the deductible levels above will increase by $5,000.

Inpatient Reinsurance cases shall be generated automatically based on fully adjudicated (i.e., accepted) encounters submitted to ADHS and subsequently to AHCCCS. All inpatient Reinsurance claims are subject to medical review by ADHS and AHCCCS.

Annual inpatient Reinsurance Deductible levels, co-insurance percentages, and Eligible services are subject to change upon notice from ADHS. Any such changes will be appropriately factored into capitation rate development and the Reinsurance offsets to those rates.

(b). Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses Members receiving certain Biotech Drugs and those Members diagnosed with Gaucher's disease. For additional detail and restrictions refer to the AHCCCS Reinsurance Claims Processing Manual and the AHCCCS AMPM. There are no Deductibles for Catastrophic Reinsurance cases. For Members receiving biotech drugs for other than Gaucher's disease, the ADHS will reimburse eighty-five percent (85%) of the Contractor's paid amount or the AHCCCS, or Contractor allowed amount, whichever is lower, depending on the subcap code, for the cost of the drugs only. For those Members diagnosed with Gaucher's disease, all medically necessary Covered Services provided during the Contract Year shall be eligible for reimbursement at eighty-five percent (85%) of the Contractor's paid amount or the AHCCCS, or Contractor allowed amount, whichever is lower, depending on the subcap code. All Catastrophic Reinsurance claims are subject to medical review by ADHS and AHCCCS.

The Contractor shall notify ADHS, of cases identified for Catastrophic Reinsurance coverage for Members with Gaucher's Disease within thirty (30) days of (a) initial Diagnosis, (b) enrollment with the Contractor, and (c) at the beginning of each Contract Year. Catastrophic Reinsurance will be paid for a maximum thirty (30) day retroactive period from the date of notification to ADHS. The determination of whether a case or type of case is catastrophic shall be made by the AHCCCS Director or designee based on the following criteria; 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

(c). Gaucher's Disease: Catastrophic Reinsurance is available for Members diagnosed with Gaucher's

disease classified as Type I and who are dependent on enzyme replacement therapy.

(d). Biotech Drugs: Catastrophic Reinsurance is available to cover the cost of Biotech Drugs when medically necessary. The Biotech Drugs currently covered are Cerazyme, Alduazyme, Fabryzyme, Myozyme and Elaprase. ADHS will review the Biotech Drugs covered under Catastrophic Reinsurance at the start of each Contract Year. ADHS reserves the right to require the use of a generic equivalent when applicable. ADHS shall reimburse at the lesser of the Biotech Drug cost or the cost of its generic equivalent for Catastrophic Reinsurance purposes.

(e) For both Inpatient and Catastrophic Reinsurance case types (Gaucher's disease and Biotech Drugs), the Contractor will be reimbursed one hundred percent (100%) of the lesser of Contractor paid amount or AHCCCS, or Contractor, allowed amount, depending on the subcap code, for all medically necessary services paid under the case type after the Contractor paid amount reaches $650,000. The Contractor shall notify ADHS once a Reinsurance case reaches $650,000. The Contractor shall split encounters as necessary once the Reinsurance case reaches $650,000. Failure to notify ADHS or failure to split and adjudicate encounters appropriately within fifteen (15) months from the end date of service shall disqualify the related encounter for one hundred percent (100%) reimbursement consideration.

(f). Encounter Submission and Payments for Reinsurance

i. Encounter Submission: A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to ADHS, who will subsequently submit the encounters to AHCCCS. The Contractor shall submit encounter data for Reinsurance in accordance with the CRS File Layout and Specification

Manual and Reinsurance requirements in the Office of Program Support Operations and Procedures Manual.

The Contractors' Reinsurance associated encounters shall reach a Clean Claim status at ADHS within twelve (12) months and at AHCCCS within fifteen (15) months from the end date of service, or date of eligibility posting, whichever is later. Encounters for Reinsurance claims that have passed the fifteen (15) month deadline and are being adjusted due to a Claim Dispute or State Fair Hearing decision shall be submitted and pass all encounter and Reinsurance edits within ninety (90) calendar days of the date of the Claim Dispute decision or Hearing decision, or Director's decision, whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss of any related Reinsurance dollars.

The Contractor shall void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. For replacement encounters resulting in an increased claim value, the replacement encounter must reach adjudicated status within 15 months of end date of service to receive additional Reinsurance benefits.

ii. Payment of Inpatient and Catastrophic Reinsurance Cases: ADHS will reimburse a Contractor for costs incurred in excess of the applicable Deductible level, subject to co-insurance percentages and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the Deductible level shall

be paid based upon costs paid by the Contractor, minus the co-insurance and Medicare/TPL payment, unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, ADHS shall base reimbursement of Reinsurance encounters as described above minus the co-insurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest.

iii. The Contractor shall cooperate with and participate in the Reinsurance audits conducted by ADHS and other Reinsurance audits as directed by AHCCCS. Upon request, the Contractor shall provide requested medical records and financial documentation in accordance with Reinsurance requirements in the Office of Program Support Operations and Procedures Manual.

(3). Risk Corridor for Title XIX and Title XXI Members: The Contractor shall accept ADHS's established limits (i.e., risk corridors) on the Contractor's potential profits and losses. These profit and loss corridors apply to the profits and losses derived from this Contract and apply to the aggregate of the Contractor's Title XIX and Title XXI income/revenue under this Contract (i.e., capitation and Reinsurance payments). If profit is determined to exceed the permissible amount, ADHS shall reduce payments to the Contractor.

The amount of any sanctions imposed on the Contractor will not be included as an expense for the purpose of calculating profit or loss. Performance incentives earned under this Contract shall not be included as revenue for the purpose of calculating profit or loss corridors. Similarly, funds recouped from the Contractor related to Performance Guarantees shall not be included as an expense (or a reduction to revenue) for the purpose of calculating profit or loss corridors.

(4). Profit and Loss Corridors. The Contractor's profit and loss corridors shall be calculated as follows:

The Contractor's profits and losses for Title XIX and Title XXI shall be limited to four percent (4%) of service revenue per Contract Year. Service revenue equals eighty-eight percent (88.0%) of total CRS-related Title XIX and Title XXI payments, adjusted for payables and receivables to/from ADHS.

The Contractor agrees that ADHS may calculate profits and losses as described above as service revenues less service expenses. Service expenses will be calculated based on submitted and adjudicated/approved encounters, utilizing the paid amount, or in the case of a subcapitated arrangement utilizing the lesser of the AHCCCS, or Contractor allowed amount for the particular service. All amounts reported as "paid" on encounters shall be subject to verification at the discretion of ADHS. The Contractor shall return excess profits to ADHS. ADHS shall reimburse the Contractor for excess losses, subject to funding availability.

There will be an interim calculation of the profit/loss corridor to occur no sooner than nine (9) months after Contract Year End. A Final calculation of the profit/loss corridor will occur no sooner than eighteen (18) months after the Contract Year End. Any Reinsurance payments made subsequent to the profit/risk corridor calculation will be cause for adjustment to that calculation.

B. Non-Title XIX and Non-Title XXI Payments

The Contractor shall receive Non-Title XIX and Non-Title XXI funds (i.e., State-Only funds) in twelve (12) monthly installments through the Contract Year. These funds shall represent reimbursement in full for all Contractual requirements associated with Non-Title XIX and Non-Title XXI Members. The Contractor shall manage available Non-Title XIX and Non-Title XXI funds to continuously deliver Covered Services and perform other associated Contract requirements throughout the entire Contract Year.

C. Performance Guarantees and Incentives

(1). Earning Performance Guarantees and Incentives

The Contractor may earn Performance Guarantees and Incentives based on the following:

(a). The Contractor shall be at risk to pay ADHS up to half a percent (.50 %) of the annual Title XIX and Title XXI capitation payment as a penalty if the Contractor fails to meet the MPTs on the measures in the matrix attached to this Contract as Exhibit C. The Contractor agrees that the penalty shall be charged against the Contractor's administrative allocation portion of the monthly capitation payment and shall not reduce or diminish service delivery in any way.

(b). The Contractor may earn an incentive up to one percent (1%) of the annual Title XIX and Title XXI capitation payment if the Contractor meets or exceeds the measures in the matrix attached to this Contract as Exhibit C.

The Contractor shall receive the half percent (.50%) at risk payment for Performance Guarantees as part of the monthly capitation payments (i.e., these funds are not withheld up front). This half percent will be subject to a quarterly penalty administration, if applicable. The one percent (1%) allocated to incentives shall be withheld from the capitation and incentive payments shall be administered as performance thresholds are met. The penalty and incentive allocation for each metric is the percent as stated in the matrix in Exhibit C. Data quality standards specified in the CPPM Section 11.0 must be met for the Contractor to be eligible for Performance Guarantees and Incentives.

The Contractor agrees Performance Guarantees and Incentives shall become effective on the Contract Effective Date and remain in effect for a period of twelve (12) consecutive calendar months and will automatically renew at the start of each new Contract Year unless otherwise modified. The Contractor shall receive advance written notice of any changes in Performance Guarantee or Incentive measures, thresholds, goals, and related in accordance with terms of this Contract.

The Contractor shall submit performance reports on established metrics to ADHS on a month-by-month and annual basis or upon ADHS's request, quarter-by-quarter basis and year-to-date annualized reports. The Contractor shall submit reports in accordance with the established metrics in this Contract, Exhibit B, and not based on a book-of-business method.

(2). Performance Guarantee Incentive Reporting

The Contractor shall submit summaries of performance to the CRSA Division of Quality Management as follows:

(a). Monthly Report on Established Performance Guarantees within thirty (30) days after each monthly measurement period;

(b). Quarterly Report on Established Performance Guarantees within thirty (30) days after each quarterly measurement period; and

(c). Annual Report on Established Performance Guarantees within forty-five (45) days after the fiscal year end.

(3). Performance Guarantee Incentive Measurement

The Contractor shall measure performance for each standard on the performance for the period as defined in each standard as follows:

(a). For monthly metrics, the fees at risk and incentives available are defined as one-twelfth (1/12) of the annual fees and incentives available.

(b). For quarterly metrics, the fees at risk and incentives available are defined as one-fourth (1/4) of annual fees and incentives available.

(c). For semi-annual metrics, the fees at risk and incentives available are defined as one-half (1/2) of annual fees and incentives available.

(d). For annual metrics, the fees at risk and incentives available are defined as those fees and incentives available during the year.

(4). Penalty Assessments

The Contractor agrees that:

(a). Any penalty amount shall be deducted from the monthly capitation check disbursed subsequent to an ADHS determination that the Contractor's performance does not meet established thresholds.
(b). Administration of penalty assessments are performed at the end of each quarter based on monthly quarterly, semi-annual or annual results, as specified for each standard.
(c). The incentive payments will be calculated quarterly and payment will be made annually by wire transfer.

The Contractor shall receive/pay any monies owed with respect to these guarantees and incentives within one hundred and twenty (120) days of the termination of the Contract.

The Contractor shall cooperate with ADHS in its verification and audit of all performance measurement results. For performance guarantee measurement purposes, the Contractor shall submit self-reported results, which are subject to a data integrity analysis. Unless otherwise approved by ADHS, the Contractor's maximum error rate in submitted data shall be five percent (5%). The Contractor shall pay a penalty based on the applicable metric when its submitted data submission does not meet the thresholds for accuracy.

The Contractor shall cooperate with ADHS if, in its sole discretion, ADHS decides to perform an independent audit each year covering a three-(3) or more month period of the performance guarantee year. If the results of the independent audit are below the Contractor's self-reported results for the period under review, the Contractor shall agree to the independent audit results as the basis for Performance Guarantee measurement for the full year or until the Contractor demonstrates that the reliability of its self-reported results are consistent with independent audit results.

D. Recoupments

The Contractor shall reimburse to ADHS immediately upon demand.

(1). All Contract funds expended that are deemed by ADHS or the Arizona Auditor General not to have been disbursed by the Contractor in accordance with the terms of this Contract.

(2). Any recoupments imposed by AHCCCS or the Federal government and passed through to the Contractor. If the party responsible to repay the Contract payments is other than the Contractor, the Contractor shall cooperate with ADHS to identify the responsible party(ies).

H. IMPLEMENTATION

Under the direction of ADHS, the Contractor shall implement this Contract by the Contract Effective Date in a manner that results in Members receiving well-coordinated, Covered Services and preserves continuity of care throughout any transitions.

The Contractor shall implement all of the requirements in this Contract, which includes all documents incorporated by reference, Contract Amendments, and the Offeror's proposal and its Amendments.

The Contractor shall have a sufficient number of qualified staff with necessary experience and expertise to effectively implement this Contract by required deadlines and the Contract Effective Date.

The Contractor shall develop, implement, and monitor a comprehensive implementation plan that contains all of the necessary tasks, responsible personnel and deadlines by which tasks will be completed to complete Contract Implementation by the Contract Effective Date. The Contractor shall submit the implementation plan for prior approval to ADHS. The Implementation Plan shall incorporate transition and implementation tasks identified in Exhibit F and section "K. Transitions and Implementation" of the Special Terms and Conditions.

ATTACHMENTS

ATTACHMENT A – OFFER AND ACCEPTANCE SIGNED BY AUTHORIZED PERSON

	OFFER AND ACCEPTANCE **SOLICITATION NUMBER: HP832090**	**ARIZONA DEPARTMENT OF HEALTH SERVICES** 1740 West Adams Street Phoenix, Arizona 85007 (602) 542-1040 (602) 542-1741 Fax

Submit this form with an original signature to the:

Arizona Department of Health Services
Office of Procurement
1740 West Adams, Room 303
Phoenix, Arizona 85007

The Undersigned hereby offers and agrees to furnish the material, service or construction in compliance with all terms, conditions, specifications and amendments in the solicitation.

Arizona Transaction (Sales) Privilege Tax License No:

Federal Employer Identification No:

For Clarification of this Offer, Contact:

Name: _____

Telephone: _____

FAX: _____

Company Name

Signature of Person Authorized to Sign Offer

Address

Printed Name

City, State, ZIP Code

Title

OFFER ACCEPTANCE AND CONTRACT AWARD (For State of Arizona Use Only)

Your Offer is hereby accepted as described in the Notice of Award. The Contractor is now bound to perform based upon the Solicitation and the Contractor's Offer as accepted by the State.

This Contract shall henceforth be referred to as Contract Number: HP832090

The Contractor is hereby cautioned not to commence any billable work or provide any material, service or construction under this contract until the Contractor receives an executed purchase order or contract release document or written notice to proceed, if applicable.

State of Arizona

Awarded this _____ day of _____, 20_____

_____
PROCUREMENT OFFICER

ATTACHMENT B – PRICE SHEET

PMPM Bid Amount for Title XIX and Title XXI Populations to perform associated Contractual requirements, exclusive of payment for the delivery of Covered Services.

Assumed Membership	Title XIX and Title XXI Price Bid (PMPM)
Half of population (assume 8,000)	$
Entire population (assume 16,000)	$

ATTACHMENT C – NETWORK LISTS

Provider

Bidder Name:

Providers with Contract or Letter of Intent Only

	Contract=C Letter of Intent=L	Provider Name	Street Address	City	State	Zipcode	Phone	County	Provider Type	Specialty	Area Served	Hospital Privileges	Additional Information
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Facilities

Bidder Name:

	Contract=C Letter of Intent=L	Facility Name	Facility Type	Street Address	City	State	Zipcode	Phone	County	Service Type	Services Available	Type of Providers	# of Providers (if applicable)	Additional Information
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EXHIBITS

EXHIBIT A – MULTI-SPECIALTY, INTERDISCIPLINARY CLINICS

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
Cardiac	• Cardiologist • EKG Technician • Registered Nurse	• Child Life Specialist • Educator • Social Worker • Translator • Advocate
CF (Cystic Fibrosis) Interdisciplinary	• Pulmonologist • Nutritionist • Psychologist • Registered Nurse Coordinator • Respiratory Therapist • Social Worker • Primary Care Giver • CRS Member/Caregiver	• Child Life Specialist • Educator • Translator • Patient Advocate
Craniofacial/Orofacial Interdisciplinary	• Audiologist • Child Life Specialist • Educator • Nutritionist • Oral Surgeon • Orthodontist • Pediatrician • Plastic Surgeon • Psychologist • RN Nurse Coordinator • Dentist • Social Worker • Speech Therapist • Geneticist • Genetic Counselor/Nurse • CRS Member/Caregiver • Otolaryngologist	• Translator • Advocate
Dental/Orthodontia	• Dentist/Orthodontist • Dental Technician	• Child Life Specialist • Educator • Social Worker • Translator • Advocate
Endocrine	• Endocrinologist • Registered Nurse	• Child Life Specialist • Educator • Social Worker • Translator • Advocate

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
ENT (Ear, Nose, and Throat)	• Audiologist • Otolaryngologist • LPN	• Child Life Specialist • Educator • Social Worker • Translator • Registered Nurse • Advocate
Epilepsy Interdisciplinary Surgical Clinic	• Pediatrician • Pediatric Neurologist • Registered Nurse • Social Worker • Psychologist	• Child Life Specialist • Educator • Translator • Advocate
Feeding Clinic	• Nutritionist • Occupational Therapist • Speech Therapist	• Child Life Specialist • Educator • Social Worker • Translator • Advocate
Gastroenterology	• Gastroenterologist • Registered Nurse	• Educator • Nutritionist • Advocate
Genetics	• Genetics Counselor/Nurse • Geneticist	• Child Life Specialist • Educator • Registered Nurse/Medical Assistant • Social Worker • Translator • Advocate
Metabolic Interdisciplinary	• Primary Care Physician • CRS member/caregiver • Genetics Counselor Or Genetics Nurse • Geneticist • Metabolic Nutritionist* • Psychologist • Registered Nurse Coordinator (may be same as Genetic Nurse/Counselor) * Team member for conditions amenable to nutritional management	• Educator • Child Life Specialist • Social Worker • Translator • Advocate
MM-NS (Myelomeningocele-Neurosurgery)	• Neurosurgeon • Registered Nurse	• Child Life Specialist • Educator • Nutritionist • Psychologist • Social Worker • Translator • Advocate

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
MM-Ortho (Myelomeningocele-Orthopedics)	• Orthopedic Surgeon • Registered Nurse/LPN • Orthotist	• Child Life Specialist • Educator • Nutritionist • Cast Room Tech • Occupational Therapist • Social Worker • Translator • Advocate
MM-Planning Interdisciplinary	• Neurosurgeon • Nutritionist • Occupational Therapist • Orthopedist • Pediatrician • Bowel/Bladder/RN Specialist • Social Worker • Urologist • Physical Therapist • Psychologist • Genetics Counselor/Nurse	• Child Life Specialist • Translator • Educator • Wound Care Mgmt RN/PT Specialist • Cast Tech • Orthotist • Advocate
Neurology	• Pediatric Neurologist • Registered Nurse	• Child Life Specialist • Educator • Social Worker • Translator • Advocate
Neurofibromatosis/ Neurocutaneous	• Geneticist • Member Neurologist • Pediatrician • Member Psychologist • Registered Nurse Coordinator • Social Worker • Genetic Counselor/Nurse • Educator • Psychiatrist • CRS member/caregiver • Vocational rehabilitation for teenagers	• Child Life Specialist • Translator • Audiologist • Advocate
Neurosurgery	• Neurosurgeon • Registered Nurse	• Educator • Social Worker • Child Life Specialist • Translator • Advocate

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
Ophthalmology	• Ophthalmologist • Medical Assistant	• Registered Nurse • Child Life Specialist • Educator • Social Worker • Translator • Advocate
Orthopedic-Amputee	• Orthopedic Surgeon • Registered Nurse/LPN	• Child Life Specialist • Educator • Physical Therapist • Social Worker • Translator • Cast Room Tech • Prosthetist • Advocate
Orthopedic- Cerebral Palsy	• Orthopedic Surgeon • Occupational Therapist • Physical Therapist • Registered Nurse/LPN • Social Worker	• Child Life Specialist • Educator • Nutritionist • Translator • Orthotist • Cast Room Tech • Wheelchair Tech • Advocate
Orthopedic-General	• Orthopedic Surgeon • Registered Nurse/LPN	• Child Life Specialist • Educator • Social Worker • Translator • Cast Room Tech • Orthotist • Physical Therapist • Advocate
Orthopedic-Hand	• Hand Surgeon • Orthopedic Surgeon • Occupational Therapist • Registered Nurse/LPN	• Child Life Specialist • Educator • Social Worker • Translator • Orthotist • Advocate
Orthopedic-Scoliosis	• Orthopedic Surgeon • Registered Nurse Coordinator • Registered Nurse with experience • with spinal deformities (may be the same as Nurse Coordinator)	• Child Life Specialist • Physical Therapist • Social Worker • Translator • Orthotist • Advocate • X-Ray Technician

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
Pediatrics	• Pediatrician • LPN or MA (Medical Assistant)	• Child Life Specialist • Educator • Social Worker • Translator • Audiologist • Registered Nurse • Advocate
Pediatric Surgery	• Pediatric General Surgeon • Registered Nurse	• Child Life Specialist Educator • Social Worker • Translator • Nutritionist • Ostomy Specialist • Advocate
Plastics Surgery Clinic	• Plastic Surgeon • Registered Nurse • Speech Therapist	• Child Life Specialist • Educator • Otolaryngologist • Social Worker • Translator • Audiologist • Wound Specialist • Advocate
Pulmonary	• Pulmonologist • Registered Nurse	• Child Life Specialist • Educator • Social Worker • Translator • Advocate
Rheumatology	• Rheumatologist • Registered Nurse	• Child Life Specialist • Educator • Physical Therapist • Social Worker • Translator • Advocate
Rhizotomy Review Team Meeting (not a clinic)	• Orthopedic Surgeon • Pediatric Neurologist • Neurosurgeon • Pediatrician • Occupational Therapist • Physical Therapist • Psychologist • Social Worker • Registered Nurse • Specialty RNs as needed	• Child Life Specialist • Educator • Translator • Advocate

Clinics	Interdisciplinary Team Members	Interdisciplinary Team Members Available During Specialty Clinics As Needed
Sickle Cell/Hematology	• Pediatric Hematologist • Registered Nurse • Genetics Counselor (reviews charts, attends clinics when patient requires counseling)	• Educator • Translator • Social Worker • Nutritionist • Child Life Specialist • Advocate
Urology	• Urologist • Registered Nurse	• Child Life Specialist • Educator • Social Worker • Translator • Wound/Ostomy RN specialist • Bladder Training RN specialist • Advocate

EXHIBIT B – CONTRACTOR DELIVERABLES: REPORTING AND MONITORING REQUIREMENTS BY CONTENT AREA

Description and Filename	Due Date	Periodicity
Overview of CRS Program – Scope Of Work B		
Adult CF Annual Report	60 calendar days from Contract Effective Date	Annually
Adult CF Quarterly Report	1/31 4/30 7/31 10/31	Quarterly
Managed Care – Scope Of Work C		
Performance Review Reports for Subcontractors	Upon completion	Annually
Corrective Action Plans for Subcontractors	Upon receipt from Subcontractor	Annually
Notices of Action, Notices of Extension and supporting documentation	15th day of the month for the preceding month	Monthly
Delegation Review and Oversight Report, if applicable	Upon completion	Annually
Prior-Authorization Report (PriorAuth_<site>_<yyyymmdd>	15th day of the month for the preceding month	Monthly
Quarterly Inpatient Showing Report (faxed) – Contractor shall identify the name of CRS Contractor on the report	1/31 4/30 7/31 10/31	Quarterly
Annual PAC Expenses, Parent Participation/Plan Evaluation Reports for each fiscal year	60 calendar days from Contract Effective Date	Annually
AHCCCS Grievance System Report	15th day of the month for the preceding month	Monthly
Current Member Referral Report (CMR_<site>_<yyyymmdd>)	15th day of the month for the preceding month	Monthly
Monthly Denial Report (Servicedenials_<site>_<yyyymmdd>)	15th day of the month for the preceding month	Monthly

Description and Filename	Due Date	Periodicity
Service Delivery— Scope Of Work C		
New Member Enrollment Report (NME_<site>_<yyyymmdd>)	15th day of the month	Monthly
Enrollment Transition Information (ETI) form, AHCCCS exhibit 520-2 (60 days prior to the 21st birthday of aging out member)	15th day of the month	Monthly
Call Volume and Call Type reports	15th day of the month	Monthly
Quarterly Language Line Reports	15th day of the month	Monthly
Network— Scope Of Work D		
Quarterly Telemedicine Reports	1/31 4/30 7/31 10/31	Quarterly
Out-of-Network Placement Summary	1/31 4/30 7/31 10/31	Quarterly
Network Status Report	1/31 4/30 7/31 10/31	Quarterly
Semi-Annual Field Clinic Schedule for the Period of January 1 thru June 30, for the period of July 1 thru December 31 (Field_clinic_schedule_<site>_<yyyymmdd>)	12/1 6/1	Semi-annually
Monthly Capacity/Scheduled/No Shows Report (Noshow_<site>_<yyyymmdd>)	15th day of the month for the preceding month	Monthly
Monthly Field Statistical Reports (Field_stat_report_<site>_<yyyymmdd>)	15th day of the month for the preceding month	Monthly
Network Development and Management Plan	1st day of Contract Effective Date	Annually
Copy of Sub-Contractors Provider/Management Service Agreements for each fiscal year	60 calendar days from Contract Effective Date	Annually
Network Impairment Notification	(1) business day of unexpected change	Other

Description and Filename	Due Date	Periodicity
Plan to Address Gap or Deficiency in Network	Within 30 calendar days of Contractor knowledge of gap or deficiency	Other
Administration – Scope Of Work E		
Notification of Changes in Key Personnel	Within 3 business days o Contractor knowledge of change	Other
Corporate Compliance Plan	60 calendar days from Contract Effective Date	Annually
Business Continuity and Recovery Plan (updates/revisions)	10 calendar days from Contract Effective Date	Annually
Listing of Educational Sessions attended by staff/providers with copies of agenda and sign-in sheets: Cultural Competency Business Continuity/Recovery Plan Advance Directives (including Community education)	90 calendar days from Contract Effective Date	Annually
Member/Provider Fraud and Abuse Report	Reported immediately	Other
MIS— Scope Of Work F		
QOC Data Reports (QOC_<site>_<yyyymmdd>)	15th day of the month for the preceding month	Monthly
Corrected Pended Encounter Data per Submission Requirements	Per CRS OPS Manual	Monthly
New Day Encounter Submission Requirements	Per CRS OPS Manual	Monthly
Description of patient accounting (member & claims), medical record and special cost keeping instructions (general accounting and cost accounting) systems used in carrying out the requirements of this contract.	120 calendar days from Contract Effective Date	Annually
Submission of Encounters	Within 210 calendar days of the date of service, but with final cutoff of 12/31 for Encounter from prior contract year.	Other

Description and Filename	Due Date	Periodicity
Financial Management and Practices— Scope Of Work G		
Quarterly Financial Statement a. Balance Sheet b. Income Statement c. Certification Statement*	30 calendar days following quarter end; 40 days following 4th quarter end	Quarterly
Draft Audited Financial Statement for each Fiscal Year a. Balance Sheet b. Income Statement c. Management Letter	75 calendar days following fiscal year end	Annually
Final Audited Financial Statement for each fiscal year a. Balance Sheet b. Income Statement c. Certification Statement d. Management Letter e. Reconciliation of audited financial statements-year to date, 4th quarter financial statements f. Accountants Report on Compliance g. Financial Disclosure Report	100 calendar days following fiscal year end	Annually
Performance Bond	Included with signed Contract	Other
Certificate of Insurance	Included with signed Contract	Other
Performance Guarantees	As described in Exhibit C	Other
AD Hoc Reporting		
Ad Hoc Reports	As determined by ADHS in consultation with the Contractor	Other

EXHIBIT B (2) – CONTRACTOR DELIVERABLES: REPORTING AND MONITORING REQUIREMENTS BY DUE DATES

Description and Filename	Reference	Due Date
Monthly		
Prior-Authorization Report (PriorAuth_<site>_<yyyymmdd>	SOW C	15th day of the month for the preceding month
Notices of Action, Notices of Extension and supporting documentation	SOW C	15th day of the month for the preceding month
AHCCCS Grievance System Report	SOW C	15th day of the month for the preceding month
Current Member Referral Report (CMR_<site>_<yyyymmdd>)	SOW C	15th day of the month for the preceding month
Monthly Denial Report (Servicedenials_<site>_<yyyymmdd>)	SOW C	15th day of the month for the preceding month
Monthly Language Line Usage Reports	SOW C	15th day of the month for the preceding month
Monthly Call Volume and Call Type Reports	SOW C	15th day of the month for the preceding month
Monthly Capacity/Scheduled/No Shows Report (Noshow_<site>_<yyyymmdd>)	SOW D	15th day of the month for the preceding month
Monthly Field Statistical Reports (Field_stat_report_<site>_<yyyymmdd>)	SOW D	15th day of the month for the preceding month
New Member Enrollment Report (NME_<site>_<yyyymmdd>)	SOW C	15th day of the month
Enrollment Transition Information (ETI) form, AHCCCS exhibit 520-2 (60 days prior to the 21st birthday of aging out member)	SOW C	15th day of the month
QOC Data Reports (QOC_<site>_<yyyymmdd>)	SOW F	15th day of the month for the preceding month
Corrected Pended Encounter Data per Submission Requirements	SOW F	Per CRS OPS Manual
New Day Encounter Submission Requirements	SOW F	Per CRS OPS Manual

Quarterly		
Adult CF Quarterly Report	SOW B	1/31 4/30 7/31 10/31
Quarterly Inpatient Showing Report (faxed) – Contractor shall identify the name of CRS Contractor on the report	SOW C	1/31 4/30 7/31 10/31
Quarterly Language Line Reports	SOW C	1/31 4/30 7/31 10/31
Quarterly Telemedicine Reports	SOW D	1/31 4/30 7/31 10/31
Out-of-Network Placement Summary	SOW D	1/31 4/30 7/31 10/31
Network Status Report	SOW D	1/31 4/30 7/31 10/31
Quarterly Financial Statement a. Balance Sheet b. Income Statement c. Certification Statement*	SOW G	30 calendar days following quarter end; 40 days following 4th quarter end
Semi-Annually		
Semi-Annual Field Clinic Schedule for the Period of January 1 thru June 30, for the period of July 1 thru December 31 (Field_clinic_schedule_<site>_<yyyymmdd>)	SOW D	12/1 6/1

Annually		
Adult CF Annual Report	SOW B	60 calendar days from Contract Effective Date
Performance Review Reports for Subcontractors	SOW C	Upon completion
Corrective Action Plans for Subcontractors	SOW C	Upon receipt from Subcontractor
Delegation Review and Oversight Report	SOW C	Upon completion
Annual PAC Expenses, Parent Participation/Plan Evaluation Reports for each fiscal year	SOW C	60 calendar days from Contract Effective Date
Network Development and Management Plan	SOW D	1st day of Contract Effective Date
Copy of Sub-Contractors Provider/Management Service Agreements for each fiscal year	SOW D	60 calendar days from Contract Effective Date
Corporate Compliance Plan	SOW E	60 calendar days from Contract Effective Date
Business Continuity and Recovery Plan (updates/revisions)	SOW E	10 calendar days from Contract Effective Date
Listing of Educational Sessions attended by staff/providers with copies of agenda and sign-in sheets: Cultural Competency Business Continuity/Recovery Plan Advance Directives (including Community education)	SOW E	90 calendar days from Contract Effective Date
Description of patient accounting (member & claims), medical record and special cost keeping instructions (general accounting and cost accounting) systems used in carrying out the requirements of this contract.	SOW F	120 calendar days from Contract Effective Date
Draft Audited Financial Statement for each Fiscal Year a. Balance Sheet b. Income Statement c. Management Letter	SOW G	75 calendar days following fiscal year end
Final Audited Financial Statement for each fiscal year a. Balance Sheet b. Income Statement c. Certification Statement d. Management Letter e. Reconciliation of audited financial statements-year to date, 4th quarter financial statements f. Accountants Report on Compliance g. Financial Disclosure Report	SOW G	100 calendar days following fiscal year end

Other/Ad hoc		
Ad Hoc Reports		As determined by ADHS in consultation with the Contractor
Network Impairment Notification	SOW D	(1) business day of unexpected change
Plan to Address Gap or Deficiency in Network	SOW D	Within 30 calendar days of Contractor knowledge of gap or deficiency
Notification of Changes in Key Personnel	SOW E	Within 3 business days o Contractor knowledge of change
Member/Provider Fraud and Abuse Report	SOW E	Reported immediately
Submission of Encounters	SOW F	Within 210 calendar days of the date of service, but with final cutoff of 12/31 for Encounter from prior contract year.
Performance Bond	SOW G	Included with signed Contract
Certificate of Insurance	SOW G	Included with signed Contract
Performance Guarantees	SOW G	As described in Exhibit C

EXHIBIT C – PERFORMANCE GUARANTEES

Year	Performance Standard	Performance Indicator	Threshold	Goal	Risk Allocation	Incentive Allocation
Years 1 thru 4	I. Eligibility Determination	▪ Percent of applicants notified of eligibility status within fourteen (14) calendar days of submitting a complete referral. ▪ Applies to all applications and referrals received during the Contract year. ▪ Contractor reports monthly ▪ Data quality standards specified in the CPPM Section 11.0 must be met for the Contractor to be eligible for this performance guarantee ▪ Paid annually	75%	90%	Year 1: 50% Year 2: 50% Year 3: 34% Year 4: 34%	Year 1: 50% Year 2: 50% Year 3: 34% Year 4: 34%
Years 1 thru 4	II. Service Plan Development Initiated	▪ Percent of Service Plans that are developed on the date of Enrollment ▪ Applies to all newly Enrolled Members during the Contract year ▪ Contractor reports monthly ▪ Periodic audit by ADHS ▪ Paid annually	75%	90%	Year 1: 50% Year 2: 50% Year 3: 33% Year 4: 33%	Year 1: 50% Year 2: 50% Year 3: 33% Year 4: 33%
Years 3 and 4	III. Integrated Medical Record	▪ Percent of members with an integrated medical record ▪ Measured through ADHS audit of medical records ▪ Paid annually	Year 1 Establish baseline	Year 2 Establish threshold and goal	Year 1: 00% Year 2: 00% Year 3: 33% Year 4: 33%	Year 1: 00% Year 2: 00% Year 3: 33% Year 4: 33%

EXHIBIT D – HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA") BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT")

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA") BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT")

The Arizona Department of Health Services, Children's Rehabilitative Services Administration (ADHS/CRSA) and Contractor, (referred to as "Business Associate") enter into this Agreement. In the event of conflicting terms or conditions, this Agreement supersedes the Contract.

ADHS/CRSA and Business Associate intend this Agreement to comply with the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and Part 164, Subparts A and E ("Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C ("Security Rule") (both of which are incorporated herein by reference) to protect the privacy of individuals' protected health information ("PHI") in any form and to safeguard the confidentiality, integrity, and availability of Electronic PHI ("ePHI") related to this Agreement.

A. DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule and the Security Rule.

B. OBLIGATIONS OF BUSINESS ASSOCIATE REGARDING PROTECTED HEALTH INFORMATION (PHI)

1. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as required by law.
2. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.
3. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate or its agents, including subcontractors, of a use or disclosure of PHI by Business Associate or its agents, including subcontractors, in violation of the requirements of this Agreement or the Privacy Rule.
4. Business Associate agrees to report promptly to ADHS/CRSA any use or disclosure of PHI not provided for by this Agreement or the Privacy Rule of which it becomes aware.
5. Business Associate agrees to ensure that any agent, including any subcontractor, to whom it provides PHI created or received by Business Associate on behalf of ADHS/CRSA, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
6. Business Associate agrees to maintain an accounting of all disclosures of PHI to agents, including subcontractors, as provided in this Agreement.
7. Business Associate agrees to provide access, at the request of ADHS/CRSA, within five (5) business days after a written request by ADHS/CRSA, to PHI in a designated record set, to ADHS/CRSA or, as directed by ADHS/CRSA, to an individual in order to meet the requirements under 45 C.F.R § 164.524. If the requested PHI is stored off-site, Business Associate shall make the PHI available to ADHS Covered Component within ten (10) business days, to allow ADHS/CRSA time to respond to a request for access by an individual within sixty (60) calendar days.
8. Business Associate agrees to make any amendment(s) to PHI in a designated record set that ADHS/CRSA directs or agrees to pursuant to 45 C.F.R § 164.526 at the request of

ADHS/CRSA within five (5) business days after an individual's request to ADHS/CRSA to amend the individual's PHI held by Business Associate in a designated record set.

9. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI created or received by Business Associate on behalf of, ADHS/CRSA available to ADHS/CRSA or to the Secretary of the U.S. Department of Health and Human Services ("Secretary"), for purposes of the Secretary determining ADHS/CRSA's compliance with the Privacy Rule.
10. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for ADHS/CRSA to respond to a request by an individual for an accounting of disclosures of PHI according to 45 C.F.R. § 164.528.

C. OBLIGATIONS OF BUSINESS ASSOCIATE REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

1. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Business Associate creates, receives, maintains, or transmits on behalf of ADHS/CRSA.
2. Business Associate agrees to ensure that any agent, including any subcontractor, to whom Business Associate provides ePHI, agrees to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the ePHI.
3. Business Associate agrees to report promptly to ADHS/CRSA any security incident of which Business Associate becomes aware that involves PHI created, received, maintained, or transmitted by Business Associate and any agent, including any subcontractor.
4. Business Associate agrees to make its policies, procedures, and the documentation required by the Security Rule available to ADHS/CRSA and to the Secretary for purposes of determining ADHS/CRSA's compliance.

D. OBLIGATIONS OF BUSINESS ASSOCIATE REGARDING ELECTRONIC DATA TRANSACTIONS STANDARDS

1. Business Associate agrees to comply with the Electronic Data Transactions Standards, 45 C.F.R. Part 162, Subparts I through R ("Transactions Rule") if Business Associate conducts any standard transactions for or on behalf of ADHS/CRSA Covered Component.
2. Business Associate agrees to require any agent, including any subcontractor, involved in conducting standard transactions, for or on behalf of ADHS/CRSA, to comply with the Transactions Rule.
3. Business Associate agrees that Business Associate and any agent, including any subcontractor, shall not enter into any agreement related to conducting standard transactions for or on behalf of ADHS/CRSA that:
    i. Changes the definition, data condition, or use of a data element or segment in a standard transaction;
    ii. Adds any data elements or segments to the maximum defined data set;
    iii. Uses any code or data element that is marked "not used" in the standard transaction's implementation specification or that is not in the standard transaction's implementation specifications; or
    iv. Changes the meaning or intent of the standard transaction's implementation specifications.

E. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

1. General Use and Disclosure

Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of ADHS/CRSA, as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule, or the Security RuleI, if done by ADHS/CRSA or the minimum necessary policies and procedures of the ADHS/CRSA.

2. Specific Use and Disclosure

i. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
ii. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
ii. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to ADHS/CRSA as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
iv. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).
v. Under 45 C.F.R. § 164.502(d)(2), de-identified information does not constitute PHI and is not subject to the terms of this Agreement.

F. TERM AND TERMINATION

1. Term
The Term of this Agreement shall begin on the effective date of the Contract and shall terminate when all of the PHI provided by ADHS/CRSA to Business Associate, or created or received by Business Associate on behalf of ADHS/CRSA, is destroyed or returned to ADHS/CRSA, or, if it is infeasible to return or destroy all PHI, the term of the Agreement shall terminate, except to the extent protections are extended to any PHI not returned or destroyed, according to the termination provisions in this Section.
2. Termination for Cause
Upon ADHS/CRSA's knowledge of a material breach by Business Associate of the terms of this Agreement, ADHS/CRSA shall:
i. Terminate this Agreement and the Contract if Business Associate does not cure the breach or end the violation within the time specified by ADHS/CRSA;
ii. Immediately terminate this Agreement and the Contract; or
iii. Report the violation to the Secretary if:
(a) Termination is infeasible or
(b) Business Associate does not cure the breach or end the violation within the time specified by ADHS/CRSA.
3. Effect of Termination
i. Except as provided in paragraph (ii) of this Section, upon termination, cancellation, expiration or other conclusion of this Agreement or the Contract, Business Associate shall return or destroy all PHI received from ADHS/CRSA, or

created or received by Business Associate on behalf of ADHS/CRSA. This provision shall apply to PHI that is in the possession of agents, including subcontractors, of Business Associate. Business Associate shall retain no copies of the PHI.

ii. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to ADHS/CRSA notification of the conditions that make return or destruction infeasible. Upon verification by ADHS/CRSA that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Agreement to the PHI and limit further uses and disclosures of such PHI to the purposes that make the return or destruction infeasible, for so long as Business Associate maintains the PHI. If it is infeasible for Business Associate to recover from an agent, including a subcontractor, any PHI, Business Associate shall provide a written explanation to ADHS/CRSA. Business Associate shall require its agents, including subcontractors, to agree:
   (a) To extend the protections of this Agreement to the PHI in the possession of any agent, including any subcontractor, and
   (b) To limit any further uses or disclosures of the PHI to the purposes that makes the return or destruction infeasible, for so long as the agent, including a subcontractor, maintains the PHI.

G. AUTOMATIC AMENDMENT

Upon the effective date of any amendment to the regulations promulgated by the Department of Health and Human Services with respect to PHI, the Contract shall automatically amend such that the obligations imposed on Business Associate are brought into compliance with such regulations.

H. NOTICES

All notices or other communications by either party to the other hereunder shall be in writing and shall be deemed properly delivered (i) when received by the party; or (ii) three (3) calendar days after deposit in the United States mail of such notice or communications to the parties entitled hereto, registered or certified mail, postage prepaid, to the parties at the following address (or to such other addresses as are designated in writing to all parties):

To:
Address:

_____
_____
_____

Phone Number:

_____

E-mail Address:

_____

With a Copy to:
Address:

_____
_____
_____

Phone Number:

_____

E-mail Address:

_____

If to:
Address:

_____
_____
_____

Phone Number:

_____

E-mail Address:

_____

I. MISCELLANEOUS

a. Regulatory References
A reference in this Agreement to HIPAA, the Privacy Rule, or the Security Rule means the section as in effect or as amended, and for which compliance is required.

b. Amendment
The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for ADHS/CRSA to comply with the requirements of the Privacy Rule and HIPAA.

c. Survival
The rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement and of the Contract to the extent required by Section F(2).

d. Interpretation
Any ambiguity in this Agreement shall be resolved to permit ADHS/CRSA to comply with the Privacy Rule.

Contractor ("Business Associate") hereby acknowledges receipt and acceptance of this HIPAA Business Associate Agreement and that a signed copy must be filed with the ADHS Procurement Office, 1740 West Adams Suite 303, Phoenix Arizona 85007. _____ Signature Date Authorized Signatory's Name and Title: _____	The above referenced HIPAA Business Associate Agreement is hereby executed this _____ day of _____ 2008 by the Arizona Department of Health Services. _____ Ann M. Froio ADHS Procurement Administrator

EXHIBIT E – MINIMUM SUBCONTRACT PROVISIONS

For the sole purpose of this Attachment, the following definitions apply:

"*Subcontract*" means any contract between the Contractor and a third party for the performance of any or all services or requirements specified under the Contractor's contract with AHCCCS.

"*Subcontractor*" means any third party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS.

Subcontractors who provide services under the AHCCCS ALTCS and or the Acute Care Program must comply with the following applicable rules and statutes:

- Rules for the ALTCS are found in Arizona Administrative Code (A.A.C.) Title 9, Chapter 28. AHCCCS statutes for long term care are generally found in Arizona Revised Statue (A.R.S.) 36, Chapter 29, Article 2.
- Rules for the Acute Care Program are found in A.A.C. Title 9, Chapter 22. AHCCCS statutes for the Acute Care Program are generally found in A.R.S. 36, Chapter 29, Article 1. Rules for the KidsCare Program are found in A.A.C. Title 9, Chapter 31 and the statutes for KidsCare Program may be found in A.R.S. 36, Chapter 29, Article 4.

All statutes, rules and regulations cited in this attachment are listed for reference purposes only and are not intended to be all inclusive.

[The following provisions must be included verbatim in every contract.]

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES
No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor. (A.A.C. R2-7-305)

2. AWARDS OF OTHER SUBCONTRACTS
AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or state employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee. (A.A.C. R2-7-308)

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING
By signing this subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION
By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988
The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements (CLIA of 1988; 42 CFR 493, Subpart A).

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION
The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS (A.R.S. 41-2548; 45 CFR 74.48 (d)).

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS
The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract [42 CFR 434.70 and 42 CFR 438.6(l)].

8. CONFIDENTIALITY REQUIREMENT
Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, A.R.S. §36-107, 36-2932, 41-1959 and 46-135, AHCCCS Rules and the Health Insurance Portability and Accountability Act (CFR 164).

9. CONFLICT IN INTERPRETATION OF PROVISIONS
In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES
Contract claims and disputes shall be adjudicated in accordance with AHCCCS Rules.

11. ENCOUNTER DATA REQUIREMENT
If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES
AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. FRAUD AND ABUSE
If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the
Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of Program Integrity. All incidents of potential fraud should be reported to AHCCCS, Office of the Director, Office of Program Integrity.

14. GENERAL INDEMNIFICATION
The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

15. INSURANCE
[This provision applies only if the Subcontractor provides services directly to AHCCCS members]
The Subcontractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet Contractor's requirements. The Subcontractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Subcontractor, shall not limit the responsibility of Subcontractor to indemnify, keep and save harmless and defend the State and AHCCCS, their agents, officers and employees as provided herein. Furthermore, the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74) The requirement for Worker's Compensation Insurance does not apply when a Subcontractor is exempt under A.R.S. 23-901, and when such Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES
Except as provided in federal and state law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES
The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and
authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

18. NON-DISCRIMINATION REQUIREMENTS
The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order
99-4)

19. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT
The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies.

20. RECORDS RETENTION
The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, dental records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (45 CFR 74.53; 42 CFR 431.17; A.R.S. 41-2548)

21. SEVERABILITY
If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

22. SUBJECTION OF SUBCONTRACT
The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of covered services.

23. TERMINATION OF SUBCONTRACT
AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and
hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. (A.A.C. R2-5-501; A.R.S. 41-2616 C.; 42 CFR 434.6, a. (6))

24. VOIDABILITY OF SUBCONTRACT
This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS's prior written approval.

25. WARRANTY OF SERVICES
The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

26. OFF-SHORE PERFORMANCE OF WORK PROHIBITED
Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

27. FEDERAL IMMIGRATION AND NATIONALITY ACT
The Subcontractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

EXHIBIT F – CONTRACTOR'S TRANSITION AND IMPLEMENTATION MILESTONES AND TASKS

Item	Contractor's Tasks
Implementation Plan	Obtain ADHS approval of implementation plan
MSICs	Establish MSICs are ready to deliver care via site visit
Website	Obtain ADHS approval for website content. Test functionality
Eligibility and Enrollment Process	Obtain ADHS approval of policy, procedure and reporting.
Member Informational Materials	Obtain ADHS approval of materials (English & Spanish)
Interpretation and Translation Services	Provide ADHS with copy of subcontract
Key Personnel	Demonstrate that Key Personnel or approved interim Key Personnel are hired for start at least two weeks prior to Contract Effective Date.
Contractor Policies and Procedures Manual	Obtain ADHS approval of Contractor's policy and procedure manual.
Subcontracts	Provide ADHS with examples of all subcontract types that include requirements
Internal Communication Plan	Demonstrate mechanisms through which Subcontractors and Contractor staff can access all documents incorporated by reference in Contract.
Member/Family Communication Plan	Obtain ADHS approval of plan
Provider Communication Plan	Obtain ADHS approval of plan
Stakeholder Communication Plan	Obtain ADHS approval of plan
Staff Training	Obtain ADHS approval of plan.
New Contractor Transition Plan	Obtain ADHS approval of plan to ensure continuity of care during transition to new Contractor.
Network Sufficiency	Provide verification of network adequacy as of October 1, 2008.
MM/UM Reports	Obtain ADHS approval of example MM/UM reports
Credentialing Process	Obtain ADHS approval of credentialing process and requirements.
Integrated Medical Record Elements and Transition Plan	Obtain ADHS approval of plan. Provide evidence that records for Members will be transitioned by implementation time.
Grievance System	Obtain ADHS approval for process by which Contractor will record and resolve Grievances, Appeals and Claims Disputes.

Item	Contractor's Tasks
Grievance Tracking and Database	Test Grievance tracking system and data entry into database. Provide evidence of database compatibility with the ADHS system.
Grievance Report Templates	Obtain ADHS approval of example Grievance System reports.
Grievance System Staff	Verify qualifications of staff responsible for Grievances, Appeals and Claims Disputes.
Transition Plan	Review/approve template for transition plan. Provide evidence of transition plans for existing Members who will be transitioned by Contract Effective Date if applicable.
Encounter and Member Data Exchange	Confirm that Encounter data are compatible with ADHS data system.
Telemedicine	Obtain ADHS approval of plan for incorporation of Telemedicine services into network
Telemedicine System	Verify existence of Telemedicine equipment or subcontracts with Telemedicine service providers.
Claims Payment System	Verify that a claims payment system exists, has been tested and is functional
Process/Plan to Minimize Insolvency	Confirm Performance Bond is in place and verify minimum capitalization.
Business Continuity Plan	Obtain ADHS approval of plan.
Fraud and Abuse Reporting	Obtain ADHS approval of protocols for detection and reporting of Fraud and Abuse.
Contractor Staff Qualifications	Obtain ADHS approval of all job descriptions and policies re staff qualifications.

EXHIBIT G – BID BOND

Bid Bond

Solicitation No. HP832090

Supplier Name: _____

KNOW ALL PERSONS BY THESE PRESENTS:
THAT, _____ (hereinafter called Principal), as Principal, and _____, a corporation organized and existing under the laws of the State of _____ with its principal office in the city of _____ (hereinafter called the Surety), as Surety, are held and firmly bound unto the State of Arizona, (hereinafter called Obligee) in the amount of _____ (Dollars) ($ _____), for the payment whereof, the said Principal and Surety bind themselves and their heirs, administrators, executors, successor assigns, jointly and severally firmly by these presents.
WHEREAS, the Principal has submitted a bid for:

_____
Offeror's Name
In accordance to the Arizona Procurement Code, A.R.S. 41−2501 et seq., the State of Arizona, Department of Health Services intends to establish a contract for the Children's Rehabilitative Services Program.
For questions relating to the solicitation or procurement process, please contact Richard Szawara at 480 203-6866 or via e-mail at szawarr@azdhs.gov .

_____
NOW, THEREFORE, if the Obligee shall accept the bid of the Principal and the Principal shall enter into a Contract with the Obligee in accordance with the terms of such bid, and give such bond or bonds as may be specified in the bidding or Contract Documents with good and sufficient surety for the faithful performance of such contract and for the prompt payment of labor and material furnished in the prosecution thereof, or in the event of the failure of the Principal to enter such Contract and give such bond or bonds, if the Principal shall pay to the Obligee the difference not to exceed the penalty hereof between the amount specified in said bid and such larger amount for which the Obligee may in good faith contract with another party to perform the Work covered by said bid, then this obligation shall be null and void, otherwise to remain in full force and effect. The prevailing party in a suit on this bond shall recover as part of his judgment such reasonable attorneys'' fees as may be fixed by a judge of the Court.
Witness our hands this _____ day of _____ 2008

_____
Principal

_____
By

_____
Surety

_____
By

_____
Agency of Record

EXHIBIT H – PERFORMANCE BOND

Performance Bond

Solicitation No. HP832090

Supplier Name: _____

KNOW ALL PERSONS BY THESE PRESENTS:
THAT, _____ (hereinafter called Principal), as Principal, and _____, a corporation organized and existing under the laws of the State of _____ with its principal office in the city of _____ (hereinafter called the Surety), as Surety, are held and firmly bound unto the State of Arizona, (hereinafter called Obligee) in the amount of _____ (Dollars) ($ _____), for the payment whereof, the said Principal and Surety bind themselves and their heirs, administrators, executors, successor assigns, jointly and severally firmly by these presents.
WHEREAS, the Principal has entered into a certain written contract with the Obligee, dated the ____ day of _____2008, for the material, service or construction described as:

_____
Offeror's Name
In accordance to the Arizona Procurement Code, A.R.S. 41−2501 et seq., the State of Arizona, Department of Health Services intends to establish a contract for the Children's Rehabilitative Services.
For questions relating to the solicitation or procurement process, please contact Richard Szawara at 480 203-6866 or via e-mail at szawarr@azdhs.gov .

_____
NOW, THEREFORE, THE CONDITION OF THIS OBLIGATION IS SUCH, that if the said Principal shall faithfully perform and fulfill all the undertakings, covenants, terms, conditions and agreements of said contract during the original term of said contract and any extension thereof, with or without notice to the Surety and during the life of any guaranty required under the contract, and shall also perform and fulfill all the undertakings, covenants, terms, conditions, and agreements of any and all duly authorized modifications of said contract that may hereafter be made, notice of which modifications to the Surety being hereby waived; then the above obligations shall be void, otherwise to remain in full force and effect. The prevailing party in a suit on this bond shall recover as part of his judgment such reasonable attorneys'' fees as may be fixed by a judge of the Court.
Witness our hands this ____ day of _____2008

_____
Principal

_____
By

_____
Surety

_____
By

_____
Agency of Record

ACRONYMS AND DEFINITIONS

A.A.C.	Arizona Administrative Code
AAP	American Academy of Pediatrics
ACOM	AHCCCS Contractor Operations Manual
ACYF	Administration for Children, Youth and Families within DES
ADA	Americans with Disabilities Act of 1990
ADE	Arizona Department of Education
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
AMPM	AHCCCS Medical Policy Manual
APC	Arizona Procurement Code
A.R.S.	Arizona Revised Statutes
BBA	Balanced Budget Act of 1997
CAP	Corrective Action Plan
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMO	Chief Medical Officer or Contractor's Medical Director
CMS	Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA)

ACRONYMS AND DEFINITIONS
SOLICITATION NO. HP832090

CPPM	Contractor's Policy and Procedures Manual
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Child Protective Services
CRS	Children's Rehabilitative Services
CRSA	Children's Rehabilitative Services Administration
CRSO	Children's Rehabilitative Services Organization
DDD	Division of Developmental Disabilities within DES
DEA	Drug Enforcement Administration
DES	Department of Economic Security
DME	Durable Medical Equipment
EHI	Electronic Health Information
FCC	Family-Centered Care
FFP	Federal Financial Participation
FPL	Federal Poverty Level
G&A	Grievances and Appeals
GAAP	Generally Accepted Accounting Principles
HCFA	Health Care Financing Administration
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIeHR	Health Information Exchange, Electronic Medical Record
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IGA	Intergovernmental Agreement

ISA	Interagency Service Agreement
IT	Information Technology
LEA	Local Education Agency
LEP	Limited English Proficiency
MAPDs	Medicare Advantage Prescription Drug Plans
MCO	Managed Care Organization
MED	Medical Expense Deduction
MM	Medical Management
MPS	Minimum Performance Standard
MSIC	Multi-Specialty, Interdisciplinary Clinic
MSR	Member Service Representative
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NOA	Notice of Action
NOE	Notice of Extension of Timeframes for Service Authorization Decision
OCSHNC	Office for Children with Special Health Care Needs
OCR	Office of Civil Rights
OSHA	Occupational Safety and Health Administration
PAC	Parent Action Council
PCP	Primary Care Provider
PDPs	Medicare Prescription Drug Plans
PHI	Protected Health Information

PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMMIS	Prepaid Medical Management Information System
PMPM	Per Member Per Month
PSR	Provider Service Requisition
QI	Quality Improvement
QM	Quality Management
QMP	Quality Management Plan
QOC	Quality of Care
RBHA	Regional Behavioral Health Authority
RFP	Request for Proposal
SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act. Also known as KidsCare in Arizona
SOBRA	Sixth Omnibus Reconciliation Act
SPAC	State Parent Action Council
SSA	Social Security Act
SSI	Supplemental Security Income
TDD	Telecommunications Device for the Deaf
TPL	Third-Party Liability
UM	Utilization Management

834 Enrollment/Disenrollment Transaction – a HIPAA-compliant transmission, by a provider to the Contractor or by the Contractor to ADHS, of information to establish or terminate a person's Eligibility to receive or not receive CRS services.

Access to Care – a Members' attainment of timely and appropriate health care services.

ACOM – *AHCCCS Contractor Operations Manual*, available on the AHCCCS Website at www.azahcccs.gov.

Action – includes:
1. the denial or limited authorization of a requested service including type or level of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service;
4. the failure to provide a service in a timely manner, as set forth in Contract;
5. the failure of a Contractor to act within the time frames required for standard and expedited resolution of Appeals and standard disposition of Grievances; or
6. the denial of a rural Member's request to obtain services outside the CRS Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

Administrative Costs – administrative expenses incurred to manage the CRS program, including but not limited to – provider relations and contracting, provider billing, accounting, information technology services, processing and investigating Grievances and Appeals, Member Services, legal services (including any legal representation of the Contractor at administrative hearings concerning the Contractor's decisions, and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, MM/UM and QM. Administrative costs do not include expenses related to payment for the direct provision of Covered Services. See also Financial Reporting Guide for categories of classification.

Administrative Hearing – a hearing under A.R.S. Title 41, Chapter 6, Article 10 (also called State Fair Hearing).

Adult – a person eighteen (18) years of age or older who has not been deemed incompetent by a court of competent jurisdiction, unless the term is given a different definition by statute, rule, or policies adopted by ADHS or AHCCCS.

Advance Directive – a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated that clearly specifies how medical decisions affecting an individual are to be made if they are unable to make them or to authorize a specific person to make such decisions for them.

Agent – any person who has been delegated the authority to obligate or act on behalf of another person or entity.

AHCCCS Member – an individual who has applied for and become enrolled with AHCCCS.

American Indian Health Program – the bureau of the United States Department of Health and Human Services that is responsible for delivering public health and medical services to Native Americans.

Americans with Disabilities Act (ADA) – a Public Law 101-336 enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation.

Appeal – a request for review of an Action.

Appeal Resolution – the written determination by the Contractor concerning an Appeal.

Applicant – an individual who has requested enrollment in the CRS program and or for which ADHS has received a written, signed, and dated application.

Application Packet – The completed documents, forms and supplemental information necessary to process Eligibility for CRS as defined by A.A.C. Title 9, Chapter 7.

Arizona Administrative Code (A.A.C.) – State regulations established pursuant to relevant statutes.

Arizona Department of Health Services (ADHS) – the State Agency that oversees CRSA.

Arizona Health Care Cost Containment System (AHCCCS) – AHCCCS is the system through which Arizona's Medicaid (Title XIX) and KidsCare (Title XXI) programs are delivered. AHCCCS also refers to the State agency that oversees the Title XIX and Title XXI programs.

Arizona Long Term Care System (ALTCS) –a program under AHCCCS that delivers long term health care services to members as authorized by A.R.S. §36-2931 et seq.

Arizona Procurement Code (APC) - the portion of A.R.S. Title 41, Chapter 23 and corresponding A.A.C. R2-7-101 et seq.

Arizona Revised Statute (A.R.S.) – the laws of the State of Arizona.

Authorization Request (expedited) – under 42 CFR 438.210, means a request for which a provider indicates or the Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires, no later than three (3) working days following the receipt of the Authorization Request, with a possible extension of up to fourteen (14) calendar days if the Member or Provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the Member's best interest.

Authorization Request (standard) – under 42 CFR 438.210, means a request for which the Contractor must provide a decision as expeditiously as the Member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the Authorization Request, with a possible extension of up to fourteen (14) calendar days if the Member or Provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the Member's best interest.

Balanced Budget Act (BBA) – of 1997, Public Law 105-33, means the Federal law that increased the attention given to performance monitoring and quality assurance in both Medicaid and the newly created State Children's Health Insurance Program.

Best Practices – for children with special health care needs, Best Practices are embodied in the Maternal Child Health Bureau Title V Block Grant performance measures, which indicate that care should be coordinated, ongoing, comprehensive, culturally competent, community-based, and organized in ways that families can use them easily, that families partner in decision-making at all levels and are satisfied with the services they receive and that youth receive services necessary to make transitions to all aspects of adult life, including adult health care work and independence.

Bidder's Library – a repository of manuals, statutes, rules and other reference materials provided to Offerors to assist with the development of a proposal.

Board Certified – an individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.

Board Eligible – an individual who has successfully completed all prerequisites of their respective specialty board.

Business Day – Monday, Tuesday, Wednesday, Thursday, or Friday unless: a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

Capitation – payment to the Contractor of a fixed monthly payment per Member in advance, for which the Contractor provides a full range of Covered Services as authorized under A.R.S. §36-2942 and §36-2931.

Case Management – supportive services provided to enhance treatment progress and effectiveness.

Centers for Medicare & Medicaid Services (CMS) – the division within the United States Department of Health and Human Services, which administers the Medicare and Medicaid program and the State Children's Health Insurance Program.

Child – an eligible person under the age of eighteen (18), unless the term is given a different definition by statute, rule, or policies adopted by the ADHS or AHCCCS.

Children with Special Health Care Needs – Children who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children's Rehabilitative Services Administration (CRSA) – a subdivision of ADHS, which provides regulatory oversight of the CRS Program and the contract processes as they relate to the Contractor and the delivery of health care services.

Children's Rehabilitative Services (CRS) – a program that provides for medical treatment, rehabilitation, and related support services to eligible individuals who have certain medical, disabling, or potentially disabling conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities.

Claim Dispute (or Provider Claim Dispute) – a provider's dispute related to payment for the delivery of Covered Services. Compare to a contract claim dispute, which is a dispute related to the Contract, except for claims regarding the payment for Covered Services. Claim Disputes are not subject to the requirements for contract claims as provided by the Arizona Procurement Code, Article 9.

Clean Claim – a claim that may be processed without obtaining additional information from the Provider or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Co-insurance – co-insurance (coinsurance) a cost-sharing arrangement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of Covered Services. Health care costs that the Member is responsible for paying, based on a fixed percentage.

Community-Based Services – Covered Services provided for Members in service delivery settings such as the Member's home, school, physician's office, or hospital.

Concurrent Review – the process of reviewing an institutional stay following admission through discharge to determine ongoing medical necessity for that institutional level of care.

Contract Award Date – date on which the State Procurement Officer executes the Offer and Acceptance.

Contract Effective Date – The date on which the Contractor is required to begin delivering Covered Services to Members. For this Contract, the Contract Effective Date is October 1, 2008, unless another date is specified in the award notice.

Contract Year – October 1 through September 30.

Contractor – In addition to the definition of "Contractor" in the Uniform Terms and Conditions and the Special Terms and Conditions, the following shall apply: any non-State entity or individual with whom ADHS has contracted to administer the CRS Program as described in this Contract; also CRSO.

Contractor's Key Personnel – the Contractor's CEO, CMO, and CFO.

Contractor's Medical Director (or CMO) – the physician appointed by the Contractor to make medical decisions about the medical Eligibility of Applicants and the medical necessity of care provided to Members assigned to the Contractor. The Contractor's Medical Director also may provide medical advice and counsel to ADHS and interface with medical directors of other agencies and health plans on care coordination issues.

Coordination of Care – the process that links children and youth with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care. The care coordinator assures the implementation of the Service Plan.

Co-payment – a fixed amount that the Member pays directly to a provider at the time Covered Services are rendered.

Corrective Action Plan (CAP) – a written work plan that includes goals and objectives, corrective steps to be taken, staff responsible to carry out the CAP within established timeframes. CAPs are generally used to improve performance of the Contractor and/or its providers or to resolve a deficiency.

Covered Services – health, medical, rehabilitative and support services to be delivered by the Contractor and the Contractor's network as delineated in A.A.C. Title 9, Chapter 7, Article 4.

Credentialing – the process of obtaining, verifying and assessing information (e.g., validity of the license, certification, training and/or work experience) to determine whether providers have the required knowledge, skill and expertise to deliver services to Members.

CRS – Children's Rehabilitative Services program administered by ADHS, as defined in A.A.C., Title 9, Chapter 7.

CRS Condition – a disease, disorder or condition that qualifies for CRS coverage as identified in A.A.C. Title 9, Chapter 7, Article 2.

CRS Eligible – an individual who has completed the CRS application process, as delineated in the CPPM, and has met all applicable eligibility criteria to receive CRS-related services, but is not yet Enrolled.

CRS Member or Member – an individual who meets CRS Eligibility requirements and is enrolled with CRS.

CRS Clinic or Multi-Specialty, Interdisciplinary Clinic or MSIC – an established facility where specialists from multiple specialties meet face-to-face with Members and their families for the purpose of providing interdisciplinary services to treat the Member's CRS condition.

CRS Contractor or Contractor – an entity contracted with ADHS under a capitation arrangement to provide and manage Covered Services directly or through Sub-contractors to Members Statewide.

CRS Medical Director – the physician designated by the CRSA Administrator to provide appropriate input on medical issues to the CRSA Administrator. The CRS Medical Director has all of the responsibilities for the CRS program as defined in Arizona Statute, regulations and the CPPM.

Cultural and Linguistic Competency – the ability of a health care provider, Contractor or health organization to respond to the cultural and linguistic needs of Members and their families in health care settings.

Cultural Competence – a set of behaviors, attitudes and policies within a system, agency, organization, or among professionals that are consistent with the value of diversity and promote strategies that honor each individual's unique heritage, ethnicity and language; having cultural sensitivity relative to specific ethnic groups, i.e., understanding their customs, taboos, religious practices, fears, etc., and consequently developing services based upon this awareness.

Culture – integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines the preferred means for meeting needs and may be influenced by factors such as geographic location, lifestyle and age.

Current Procedural Terminology (CPT) – a standardized mechanism of reporting services using numeric codes as established and updated annually by the American Medical Association (AMA).

Customer – any entity that has purchased managed care or other health care services from the Offeror as currently constituted. Customers do not include companies affiliated with the Offeror, parent companies or subsidiaries.

Deductibles – amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Usually expressed in terms of an "annual" amount.

Delegated Agreement – an agreement with a qualified organization or person to perform one or more functions required to be provided by the Contractor pursuant to this Contract.

Department, the – the Arizona Department of Health Services.

Deputy Director – the Deputy Director for ADHS or his or her duly authorized representative.

Diagnosis – a determination or identification of a disease or condition by a health care professional licensed to do so.

Discharge Planning from Inpatient Facility – service planning for ongoing care after the release of a Member from an inpatient facility.

Division of Developmental Disabilities (DDD) – division within DES, which provides services throughout the State of Arizona through institutional and community-based programs to Members and adults who are developmentally disabled. DES/DDD is an AHCCCS Program Contractor for ALTCS.

Dual Eligible – a Member who is eligible for both Medicare and Medicaid.

Durable Medical Equipment (DME) – adaptive aids and devices, adaptive wheelchairs and ambulation assistive devices.

Eligibility Determination – a process of determining, through a written application and required documentation, whether an Applicant meets the Eligibility criteria for CRS.

Eligible – any individual determined by the CRS Medical Director or his or her designee to have a CRS Covered condition, and meets residency, age and citizenship requirements.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in – a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or, c) serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)].

Emergency Services – covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. [42 CFR 438.114(a)].

Encounter – a record of a health care related service, submitted by the Contractor to ADHS and processed by AHCCCS, which is rendered by a provider registered with AHCCCS to a Member on the date of service, and for which a CRS Subcontractor incurs financial liability.

Encounter Data – data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis.

Enrolled – any individual who has a CRS condition, meets the Eligibility requirements, and has signed a CRS payment agreement. An Enrolled Member is approved to receive CRS services.

Family or Family Member – a biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other Member representative responsible for making health care decisions on behalf of the Member. Family Members may also include siblings, grandparents, aunts and uncles.

Family-Centered – care that recognizes and respects the pivotal role of the family in the lives of Members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the Member.

Federal Financial Participation (FFP) – the Federal matching rate that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS as defined in 42 CFR 400.203.

Field Clinic – a “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to Members and their families than the MSICs to provide a specific set of services including evaluation, monitoring, and treatment for CRS related conditions on a periodic basis.

Filed – the receipt date as established by a date stamp.

Formulary – an approved list of pharmaceuticals for dispensing to Members for CRS-eligible conditions.

Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person, including any act that constitutes fraud under applicable Federal or State law.

(Fraud and) Abuse –practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the CRS program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Genetics – the studies of how particular traits are passed from parents to children. identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule.

Grievance – an expression of dissatisfaction by a Title XIX, Title XXI or State-only Member of Family Member about any matter other than an Action. Possible subjects for grievances include, but are not limited to:

1. The quality of care or services provided; and
2. Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievances do not include "Action(s)" as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

Grievance System – a system that includes a process for resolution of Grievances, Appeals, Claim Disputes, and access to the State Fair Hearing system and all notifications associated with those processes.

Guardianship – a person authorized under state or other law to act on behalf of the member in making health-related decisions. Examples: a parent acting on behalf of an un-emancipated minor or a parent who has petitioned for guardianship for their 18-21 year old member.

Health Care Professional – a provider who meets the qualifications to be an AHCCCS registered provider, permitted to practice independently by virtue of the provider's license such as a physician (allopathic or osteopathic), psychologist, physician assistant, registered nurse (including nurse practitioner), and clinical social worker, recognized as a Health Care Professional by AHCCCS.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – A federal law that gives patients greater access to personal medical records and more control over how personally identifiable health information is used. The regulation also addresses the obligations of healthcare providers and health plans to protect health information.

Health Plan – an organization, now referred to as an Acute Care Contractor, which contracts with the AHCCCS Administration to administer the provision of a comprehensive package of AHCCCS covered acute care services to enrolled AHCCCS members.

Home Health Services – services which can be provided in the Member's home.

Hospital – a health care institution licensed as a hospital, as defined in A.R.S. §36-2351.

Implementation Period – the period of time beginning with the Contract Effective Date and the date on which ADHS determines the Implementation Plan is complete.

Incurred But Not Reported (IBNR) – liability for service rendered for which claims have not been reported.

Inpatient – an individual who has been admitted at least overnight to a hospital for the purpose of receiving diagnostic, treatment, observation, or other Covered Services.

Integrated Medical Record – a single document in which all of the medical information listed in Chapter 9.0 of the CPPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.

Interagency Service Agreement (ISA) – an agreement between two (2) or more agencies of the State wherein an agency is reimbursed for services provided to another agency or is advanced funds for services provided to another agency.

Interdisciplinary Team – physician and non-physician professionals, the Member and Family Members who collaborate in planning, delivering and evaluating health care services.

Interdisciplinary Care – a meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the Member based on the most current information available.

Intergovernmental Agreement (IGA) – an agreement conforming to the requirements of A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952, *et seq*.).

Key Personnel – the CEO, CMO, and CFO of the Contractor. In general, key personnel are persons whose experience and knowledge is professional in nature as opposed to clerical. Professional work is that which is predominantly intellectual and varied in character (as opposed to routine, manual, mechanical or physical) and involves the consistent exercise of discretion and judgment in the theoretical principles and techniques of a recognized field of science or learning.

KidsCare – individuals under the age of nineteen (19), eligible under the State Children's Health Insurance Program (SCHIP), in households with income at or below 200% FPL. All members, except Native American members are required to pay a premium amount based on the number of children in the family and the gross family income. It is also referred to as Title XXI.

Limited English Proficiency (LEP) – A description of an individual's ability to speak and understand the English language when communication is difficult through spoken and written English.

Major Upgrade – any system upgrade or change that may result in a disruption to the following – loading of contracts, Providers, Members, issuing Prior Authorizations or the adjudication of claims.

Managed Care – systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for Members to use providers and procedures associated with the plan; and have formal programs for quality, utilization management and the coordination of care.

Managed Care Organization – for purposes of this Contract, a health care delivery system that attempts to manage care to eliminate unnecessary or ineffective treatment and improve outcomes.

Management Services Subcontractor – an entity to which the Contractor delegates some or all of the management or administrative services necessary for the operation of the Contractor, such as credentialing or managing care. Also, Management Services Subcontractor.

Management Services Agreement – an agreement with an entity in which the Contractor delegates some or all of the management and administrative services necessary for the operation of the Contractor, such as managing care, automated data processing or claims and/or encounter processing. Also Management Services Subcontract.

Marketing Materials – materials that are produced in any medium, by or on behalf of ADHS that can reasonably be interpreted as intended to market to potential enrollees.

Material Change – an alteration, modification or termination of a provider or a service within a provider network that may reasonably be foreseen to affect the quality or delivery of Covered Services provided under this Contract.

Material Omission – facts, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Medicaid – a Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a state-operated medical assistance program for specified populations.

Medical Assistance – the Title XIX portion of the AHCCCS program, which also includes SOBRA.

Medical Assistance Financial Screening Form – the DES document that identifies potential Title XIX eligibility.

Medical Director (CMO or the Contractor's Medical Director) - the physician appointed by the Contractor to make medical decisions about the medical Eligibility of applicants and the Medical Necessity of care provided to Members assigned to the Contractor. The Medical Director also may provide medical advice and counsel to ADHS and interface with medical directors of other agencies and health plans on care coordination issues.

Medical Expense Deduction (MED) – Title XIX Waiver member whose family income is more than 100% of the Federal Poverty Level (FPL) and has family medical expenses that reduce income to or below 40% of the FPL. MEDs may have a categorical link to a Title XIX category; however, their income exceeds the limits of the Title XIX category.

Medical Home – an approach to providing comprehensive health care. Care consistent with the medical home approach is care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.

Medical Management (MM) – an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).

Medically Necessary Services – as defined in A.A.C R9-22-101.B., means a medically necessary covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.

Medicare – a Federal program authorized by Title XVIII of the Social Security Act, as amended.

M**edicare Prescription Drug Improvement and Modernization Act of 2003** – means the Medicare Modernization Improvement Act of 2003 created a prescription Drug Benefit called Medicare Part D for individuals who are eligible for Medicare Part A and /or enrolled in Medicare Part B.

Member or CRS Member – an individual who meets CRS eligibility requirements and is enrolled with CRS and is entitled to receive CRS services.

Minor – an individual who is:
1. under the age of 18 years;
2. incompetent as determined by a court of competent jurisdiction; or
3. incapable of giving consent for medical services due to a limitation in the individual's cognitive function as determined by a physician.

Monitoring – the process of observing, evaluating, analyzing and conducting follow-up activities.

Multi-Specialty – the use of more than one specialty physician or dentist in the treatment of a Member.

Multi-Specialty, Interdisciplinary Clinic (MSIC) – an established facility where specialists from multiple specialties meet face-to-face with Members and their families for the purpose of providing interdisciplinary services to treat the Member's CRS condition.

Non-Quality of Care Concern - a Grievance that has no possibility of impacting a Member's health care status.

Non-Title XIX and Non-Title XXI– an individual who meets CRS medical eligibility and enrollment criteria, but does not meet Federal and State requirements for Title XIX or Title XXI eligibility.

Notice of Action – written notification of an Action that the Contractor has taken or intends to take.

Notice of Eligibility Decision – written notification of an eligibility decision made by the Contractor.

Notice of Extension of Timeframes for Service Authorization Decisions – written notification of the need for additional information in order to make a standard or expedited service authorization decision, and that the delay is in the best interest of the Member.

Notice of Hearing Request – written notification that a Member, Member representative or provider has requested an Administrative Hearing.

Office of Civil Rights (OCR) – the office is part of the US Department of Health and Human Services (HHS). Its HIPAA responsibilities include oversight of the privacy requirements.

Out-of-Network – care provided by health care providers that are not a part of the Contractor's provider network.

Out-of-Network Referral – a provisionally covered benefit that requires Prior Authorization by the Contractor for referrals to providers or facilities that are not in the network to satisfy unique health care needs of a Member.

Parent – a biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

Parent Action Council (PAC) – a local, parent-driven council consisting of members including parents of a child who is or has been a CRS Member, Adults who are or were CRS Members and the CRS Contractor. PAC members may also include professionals and members of advocacy groups. The PAC is established in accordance with A.R.S. §36-265.

Payment Responsibility – the portion of the cost of CRS services that a Member or family has agreed to pay, according to a signed Payment Agreement.

Peer Review – the review and evaluation of a practitioner's professional actions related to care of CRS Members, by a selected peer group.

Performance Improvement Project (PIP) – an initiative designed to improve the quality of significant aspects of clinical care or non-clinical services.

Performance Standards – a set of standardized indicators designed to assist ADHS in evaluating, comparing and improving the performance of its Contractors.

Physician – an individual currently licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

Post-Stabilization Care Services – covered services, related to an emergency medical condition, that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

Potential Member – a person that may be eligible for Medicaid benefits or is subject to mandatory enrollment or may voluntarily enroll in a managed care program, but is not yet enrolled in CRS.

Practice Guidelines – CRS Practice Guidelines are evidenced-based decision-making tools for managing and treating certain CRS covered conditions.

Primary Care Provider – any physician, physician assistant or nurse practitioner coordinating acute and chronic health care for medical conditions, including those conditions that are not CRS conditions.

Prior Authorization – the process by which a Contractor determines in advance whether a service is medically necessary. Prior authorization is not a guarantee of payment.

Protected Health Information (PHI) – under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

Provider – a Contractor's Subcontractor that provides Covered Services to Members. Includes facility-based providers, licensed independent professionals and providers of family support services. Also Subcontractor or network Subcontractor.

Provider Manual – a document that contains mandatory service delivery policies to guide providers in the administration and delivery of Covered Services.

Provider Services Requisition (PSR) – a request from a health care provider to a Contractor for prior authorizing a service.

Prudent Layperson – a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment, which society requires of its members for the protection of their own interest and the interests of others.

Quality of Care (QOC) - the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality of Care (QOC) Concern – a Grievance, that could potential negatively impact a Member's health care status.

Referral –any oral, written, faxed, or electronic request for services made by any person, or person's legal guardian, family member, an AHCCCS health plan, Primary Care Physician/Practitioner, hospital, school, or other State or community agency to the Contractor with or without required documentation for determining CRS Eligibility and Enrollment.

Regional Behavioral Health Authority (RBHA) – the organizations under contract with the ADHS to coordinate the delivery of covered behavioral health services to eligible behavioral health recipients in Arizona.

Reinsurance – a method of limiting the financial risk of providing services by purchasing insurance that becomes effective after set dollar amount has been reached.

Related Party – a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related Parties" include, but are not limited to, Agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Residence – the place where an individual lives.

Retrospective Review – the process of determining the medical necessity of a treatment or service post delivery of care.

RFP – Request for Proposal is the document prepared by ADHS that describes the services required and instructs prospective Offerors about how to prepare a response (proposal), as defined in R9-22-106. RFP also means "Solicitation" as defined in the Uniform Instructions.

Sanction – reprimand for breaking a law, rule or failing to meet a Contractual requirement resulting in financial penalties.

SCHIP – State Children's Health Insurance Program under Title XXI of the Social Security Act. The Arizona version of SCHIP is referred to as "KidsCare." See "KIDSCARE"

School – any public or private institution offering instruction to students of any age.

Service Plan – a document that is developed consistent with applicable Practice Guidelines, which combines the various elements of multiple treatment plans with needed family support services and care coordination activities to provide a map of the steps to be taken for each Member in achieving treatment and quality of life goals.

Sixth Omnibus Reconciliation Act (SOBRA) – the program that provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to as many eligible members born on or after October 1, 1983, as is possible.

Social Security Administration (SSA) – the Federal agency that administers SSI, SSDI, and related programs.

Special Health Care Needs – serious and chronic physical, developmental or behavioral health conditions that require medically necessary health and related services of a type or amount beyond that required by members generally. All CRS Members are considered to be Members with special health care needs.

Specialty Physician – a physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

Standard of Care - in medicine, treatment that experts agree is appropriate, accepted and widely used. Health care providers are obligated to provide Members with the Standard of Care or best practices identified for a condition.

State – the State of Arizona.

State-Only funds– State appropriations to be used by the Contractor to pay for Covered Services and Administrative Costs for Non-Title XIX and Non-Title XXI Members and for Covered Services delivered to Title XIX and Title XXI eligible persons that are not covered by Title XIX or Title XXI programs.

State Parent Action Council (SPAC) – a Statewide council consisting of two parents representing each identified geographic region of Arizona, one representative from an advocacy group, one staff member from the CRS Contractor and one representative from ADHS. The SPAC is established in accordance with A.R.S. §36-265.

State Plan – the written agreements between AHCCCS and CMS, which describe how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.

Statewide – of sufficient scope and breadth to address the health care service needs of Members throughout the State of Arizona.

Subcontractor – (1) A person, agency or organization to which ADHS or the Contractor has contracted or delegated some of its management functions or responsibilities to provide Covered Services to its Members; (2) A person, agency or organization with which ADHS has contracted or delegated some of its management/administrative functions or responsibilities; (3) A person, agency or organization with which a fiscal Agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the Contract.

Telehealth – the use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, Member care, Member education, and/or health care/medical learning (Member not present).

Telemedicine – the delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.

Termination Date – the date that a Member is no longer eligible for services.

Third-Party Liability (TPL) – the obligation of a person, entity, or program by agreement, circumstance, or otherwise, to pay all or part of the expenses incurred by an applicant or Member.

Title XIX – the Federal Medicaid Program, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services to help those families and individuals become or remain independent and able to care for themselves.

Title XIX Member – a member eligible for Federally-funded, acute care services programs under Title XIX of the Social Security Act including those eligible under the 1931 provisions of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.

Title XXI – the Federal Child's Health Insurance Program or SCHIP, known in Arizona as "KidsCare."

Title XXI Member – a member eligible for acute care services under Title XXI of the SSA, referred to in Federal legislation as the SCHIP. The Arizona version of the SCHIP is referred to as KidsCare.

Transition Period – the time period beginning on the Contract Award Date and ending on the Contract Effective Date.

Transition Plan – a plan developed for each Member in accordance with CPPM section 6.3, which includes developmentally-appropriate strategies to transition from a pediatric to an Adult system of health care and a plan that addresses changing work, education, recreation and social needs.

Treatment Plan – a written plan of services and therapeutic interventions based on a comprehensive assessment of a Member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

Urgent Medical Need – a need for care of an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the Member's health.

Utilization Management/Utilization Review – the Contractor's process to evaluate appropriateness, efficacy and efficiency of Medically Necessary Covered Services.

Virtual Clinics – integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

Vital Materials – materials that must be translated into another language if that language meets a five percent (5%) (or 1,000 person) minimum threshold. These materials include notices for denials, reductions, suspensions or terminations of services and consent forms.